CERTIFICATE OF COVERAGE

BlueChoice Advantage Plus

Benefits are provided both In-Network and Out-of-Network. Using In-Network providers generally will result in higher benefits.

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

www.BlueChoiceSC.com

803-786-8476
800-868-2528

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INTRODUCTION

BlueChoice Health Plan of South Carolina Inc. (BlueChoice) is pleased to provide you with this BlueChoice Advantage Plus product. BlueChoice Advantage Plus is an open access point-of-service product. That means Members decide at the time they need medical care whether they will go to a health care provider within the BlueChoice network (a Network Provider) or go to a non-network provider. Benefits are available in either case; however, if you use a Network Provider, you generally receive higher benefits.

A person enrolled in BlueChoice Advantage Plus is automatically entitled to both In-Network and Out-of-Network benefits as described below. A referral is not required from a Primary Care Physician or BlueChoice prior to visiting any Provider. However, Prior Authorization may be required for certain services. Please see Section 3 – Procedures for Obtaining Benefits for additional information.

In-Network benefits apply when you receive Covered Services from a BlueChoice Participating Provider. In general, these benefits provide a higher level of coverage with less out-of-pocket expense. Some benefits are only available when you receive them from a health care professional within BlueChoice's Network of Providers. Please see your Schedule of Benefits for this information. BlueChoice's Participating Providers handle all of the paperwork, so you have no bills or claim forms to submit. BlueChoice HealthPlan of South Carolina Inc. underwrites these benefits.

Out-of-Network benefits generally apply when you receive Covered Services from any licensed Provider outside of the BlueChoice Network of Participating Providers. Some services covered by the In-Network benefits are not covered by the Out-of-Network benefits. Out-of-Network benefits generally provide a lower level of coverage, and you are responsible for completing claim forms and submitting itemized bills in order to receive benefits. **You can also be billed for any amount in excess of the Allowed Amount, except where prohibited by applicable law.** Payments that you make to an Out-of-Network Provider do not contribute to your Deductible, out-of-pocket expenses or any plan maximums, unless otherwise specified. Blue Cross® and Blue Shield® of South Carolina underwrites these benefits and has arranged for BlueChoice to serve as the administrator of the Out-of-Network benefits.

Contact BlueChoice. Throughout this Certificate, there are statements that encourage you to contact BlueChoice for further information. A question or concern regarding benefits or any required procedure may be addressed to BlueChoice through the website at www.BlueChoiceSC.com or by calling Member Services at 803-786-8476 in Columbia or 800-868-2528 when outside the Columbia area.

Identification Card. When you or your enrolled Dependents seek any type of medical services or supplies, including Prescription Medications, be sure to show your identification (ID) card so the Participating Provider knows you have BlueChoice Advantage Plus. If you do not show your ID card, the Provider has no way of knowing that you are a Member of BlueChoice Advantage Plus and you may receive a bill for Covered Services.

Need your ID card? Log in to My Health Toolkit®, and your digital ID card is always available. You can view, print or share your ID card any time you need it. Download the mobile app and you'll have your digital ID card right in your pocket. You can get the app through the App Store or Google Play. Just search for My Health Toolkit.

The BlueCard® Program. The BlueCard Program is a national program in which all Blue Cross and Blue Shield licensees participate, including BlueChoice. This national program enables BlueChoice members living or traveling outside of South Carolina to receive the highest level of benefits when they get services from any Physician or Hospital designated as a BlueCard PPO Provider. Doctors and Hospitals in the BlueCard Program are considered to be Participating Providers.

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determination. If you are an individual living with disabilities or have limited English proficiency, we have free interpretive services available. **We can also give you information in languages other than English or other alternate formats.**

CERTIFICATE OF COVERAGE

This Certificate of Coverage (hereinafter "Certificate") is part of the Contract which is a legal document between BlueChoice and your Employer. The Master Group Contract, this Certificate; the Schedule of Benefits; the Master Group Application; the Membership Applications, and attached amendments, addenda, riders or endorsements, if any, constitute the entire Contract between both BlueChoice and your Employer.

The Contract is delivered in and governed by the laws of the state of South Carolina and the federal government. By enrolling in BlueChoice Advantage Plus, the Member agrees to abide by the rules of BlueChoice as outlined in this Certificate.

Members are entitled to the benefits described in this Certificate in exchange for the Premium paid to BlueChoice by the Employer on the Member's behalf. The Contract may require that the Member contribute to the required Premium. Information regarding the Premium and any portion of the Premium that the Member must pay can be obtained from your Employer.

This Certificate replaces and supersedes any Certificate that previously may have been issued to you by BlueChoice and governs Covered Services provided after the Contract Effective Date. Any subsequent Certificates issued to you by BlueChoice will, in turn, supersede this Certificate. From time to time, the Contract may be amended. When that happens, a new Certificate or amendment pages for this Certificate will be sent to you. Your Certificate should be kept in a safe place for your future reference.

How to Use This Certificate. It is important that you read the entire Certificate carefully and become familiar with its terms and provisions. Many words used in this Certificate have special meanings. These words will appear capitalized and are defined. The terms "you" and "your" as used throughout this Certificate means the Subscriber and the Subscriber's enrolled Dependents.

Benefits payable under the Contract are not assignable to a non-Participating Provider. This means that, unless otherwise required under applicable law, BlueChoice may send benefit payments to you and you will be responsible for paying the Provider.

BlueChoice offers a variety of wellness programs, including a smoking cessation program, to assist you in making positive lifestyle changes. Please contact a Member Services advocate or go to our website for more information about our programs.

Prior Authorization. BlueChoice must Authorize certain benefits in advance for the benefits to be covered. Please see Section 2.04 for the list of items and services that require prior Authorization.

The admitting Physician, the Hospital, you or someone acting on your behalf must initiate the Authorization process by notifying BlueChoice prior to admission and complying with specific authorization requirements in order for you to qualify for maximum benefits. Failure to do so may result in denial of benefits.

SECTION 1
WHAT'S COVERED

In-Network benefits apply when you receive Covered Services from a BlueChoice Participating Provider. In general, these benefits provide a higher level of coverage with less out-of-pocket expense. BlueChoice's Participating Providers handle all of the paperwork, so you have no bills or claim forms to submit. These benefits are paid based on BlueChoice's In-Network fee schedule.

There are no annual or lifetime dollar limits on Essential Health Benefits. Expenses for Covered Services will be paid according to the benefits stated in the Schedule of Benefits.

Out-of-Network benefits apply when you receive Covered Services from any licensed provider outside of the BlueChoice network of Participating Providers unless otherwise specified. Some Covered Services are only available at In-Network Providers. Out-of-Network benefits generally provide a lower level of coverage, and you are responsible for completing claim forms and submitting itemized bills in order to receive benefits, and you may be Balance Billed by the Provider, unless prohibited by applicable law. These benefits are paid based on the Allowed Amount.

Prior Authorization is required for many of the Covered Services provided under the Contract, as described in Section 2.04 of this Certificate.

1.01 Covered Health Services

Benefits for all services are subject to the provisions of the Contract, Certificate and Schedule of Benefits. In the event of a conflict between the terms of the Contract and any plan documents, summary plan descriptions, or other materials, the terms of the Contract shall control. In order to be covered, services must be Medically Necessary and performed on or after the Member's Effective Date and prior to cancellation of coverage. Benefits are subject to all limitations, Copayments, Deductibles, Coinsurance and Maximum Payment amounts, if any, as specified in this Certificate including the Schedule of Benefits.

The fact that a Physician has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an injury or illness, does not mean that the procedure or treatment is covered under the Contract. BlueChoice may, at its discretion, delegate authority to other persons or entities to provide services. Benefits will be provided to the extent and at the level shown in this Certificate and the Schedule of Benefits. This includes medical services, surgical services, and Behavioral Health services including Surgical Assistants provided by a Physician for the treatment of an illness or injury, including office visits and Hospital visits.

1.02 Provider Services

Benefits are provided for preventive care, diagnostic services, and treatment of illness or injury, when they are provided by a Provider. This includes Medically Necessary office visits, and medical, surgical, or Behavioral Health care, including Surgical Assistants, provided in a Provider's office or a 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.

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

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

3. **Preventive Services.** Health maintenance and preventive services including well-baby care and periodic checkups; immunizations and injections; health education; and voluntary family planning provided by a Participating Primary Care Physician, as described further in Section 1.17.

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

1.03 Inpatient 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, Rehabilitation 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.

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

1.04 Maternity Care

Benefits are provided for professional and facility maternity care for a Subscriber or Dependent spouse, unless and to the extend otherwise specified in the Schedule of Benefits or required by applicable law. Covered Services include those provided in a Hospital or Hospital-based birthing center. Benefits include prenatal and postpartum care for Hospital services (including use of delivery room), and medical services (including operations and special procedures such as Cesarean section), and anesthesia. Benefits for inpatient care are provided for 48 hours after normal delivery, not including the day of delivery, or 96 hours after Cesarean section, not including the day of surgery. Coverage for the newborn child shall include, but is not limited to, routine nursery care and/or routine well-baby care during the initial period of Hospital confinement. A newborn child must be enrolled, and applicable premium must be paid in order for benefits to be paid. See Section 6.03, Effective Date of Coverage.

No Authorization is required for hospitalization related to the delivery of a newborn child when the Hospital stay is 48 hours or less for a vaginal birth or 96 hours or less for a cesarean section. The day of delivery, Surgery or birth is not counted in the 48 or 96 hours. If you or the newborn are not released within these time frames, you or your Provider should contact BlueChoice for Authorization for a continued stay. If you are in a Network Hospital, the Hospital should contact us for this Authorization.

1.05 Outpatient Facility Services

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

2. **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.

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

1.06 Physical, Speech and Occupational Therapy

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

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

1.07 Chiropractic Services

Benefits are provided for office services provided by a Participating chiropractor in connection with the detection and correction by manual means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of such nerve interference, where such interference is the result of or related distortion, misalignment or subluxation of, or in, the vertebral column. Maintenance care is not Covered. Such benefits are covered when furnished by a Non-Participating chiropractor only if and to the extent indicated in the Schedule of Benefits.

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

1.08 Prescription Medication

Coverage for Prescription Medication is provided unless specifically excluded pursuant to Section 5. When covered, 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 a Member shall not exceed the quantity and benefit maximum, if applicable, as specified in the Schedule of Benefits. A list of Participating pharmacies can be found on the BlueChoice website at: www.BlueChoiceSC.com/member-center/advantage-plus-plan.

Benefits are provided only for the most cost-effective Prescription Medication available at the time dispensed whenever medically appropriate and in accordance with all legal and ethical standards. There may be additional requirements or limits on some medications on the Prescription Drug List. These requirements and limits may include:

- **Prior Authorization (PA):** If your drug requires PA, your doctor will have to get approval before we will cover your drug. Drugs that require PA are shown in the Prescription Drug List. There are different reasons a drug might require PA. One is to make sure it's being used for the condition(s) it was approved for by the

United States Food and Drug Administration (FDA). Another is because there are drugs that usually work just as well but cost less.

- **Quantity Limits (QL):** If your drug has a quantity limit, we will only cover a certain amount of the drug in a specified period of time, usually a month. This is to make sure you are using the drug safely and based on the FDA guidelines. If we determine a Member has used multiple doctors or pharmacies to obtain quantities of Prescription Drugs in excess of what is allowed or recommended, we reserve the right to require the use of a designated Provider for prescribing the medication and/or a specific pharmacy to fill all prescriptions for that medication.

- **Step Therapy (ST):** If your drug has a step therapy requirement, we will only cover designated second choice drugs if you have already tried a designated first choice drug and it didn't work for you. The reason for a particular step therapy requirement may be because there are drugs that usually work just as well but will cost you less. It may also be because some drugs are approved by the FDA specifically as second-choice drugs or as add-ons to other medication.

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

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.

For information about Prescription Medications, please refer to the Prescription Drug List which can be found on the BlueChoice website at: www.BlueChoiceSC.com/member-center/advantage-plus-plan. The Prescription Drug List shows the coverage levels, called Tiers, for most Covered drugs. Each Tier has its own copayment and/or coinsurance levels. Once you have identified the Tier which is applicable to your Prescription Medication, you can refer to your Schedule of Benefits to determine how much you will pay for a Prescription Medication based on its Tier.

If a Physician prescribes a non-generic drug, there is a less-expensive covered equivalent generic drug available, and the Member still requests the prescribed non-generic drug, then any difference between the cost of the covered generic drug and the higher cost of the non-generic drug will be the responsibility of the Member. This will be in addition to any Copayment or Coinsurance appropriate to the non-generic drug being purchased. The difference you must pay between the cost of the generic drug and the higher cost of the brand-name drug does not apply to your Deductible or your Out-of-Pocket Limit. In no instance will the Member be charged more than the actual retail price of the drug.

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.

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

1.09 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 a 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 of 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 are described in Section 3.04.

1.10 Home Health Services and Outpatient Private Duty Nursing

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

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

1.11 Hospice Services

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

1.12 Transplants

Organ transplant coverage includes all expenses for medical and surgical services a Member receives for human organ and/or tissue transplants, obtained from a Blue Distinction® Centers for Transplant Designation, while the Member is covered under this Certificate. This includes donor organ procurement.

1. Benefits for certain living donor transplants covered under this Certificate, include but are not limited to kidney, liver and specific tissue transplants. Benefits will be subject to the following conditions:
   a. When both the transplant recipient and the donor are Members, benefits will be provided for both.
   b. When the transplant recipient is a Member and the donor is not, benefits will be provided for both.
   c. When the transplant recipient is not a Member and the donor is, no benefits will be provided to either the donor or the recipient.

2. Benefits are provided for the specified transplants listed below. These benefits are subject to all other provisions of the Contract.
   - Single/double kidney, pancreas and kidney, heart, single/double lung, liver, pancreas, heart and single/double lung and bone marrow transplants.

3. Benefits may be available when a malignancy is present for high-dose chemotherapy followed by hematopoietic stem support, either autologous (the patient is the donor) bone marrow transplant, peripheral stem cell or allogeneic bone marrow transplant.

4. Benefits may be available for allogeneic bone marrow transplantation in the treatment of developmental and non-malignant diseases of bone marrow.

   Benefits for allogeneic or syngeneic bone marrow transplants described in items 3 and 4 above are available only if there are at least six of eight histocompatibility complex antigen matches between the patient and the donor and the mixed lymphocyte culture is nonreactive.

5. The following services related to tissue transplants, except fetal tissue, are covered:
   a. Blood transfusions (but not whole blood and blood plasma)
   b. Autologous parathyroid transplants
   c. Corneal transplants
   d. Bone and cartilage grafting
   e. Skin grafting

1.13 Emergency and Urgent Care Services

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 a Participating 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, 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 requirements for Emergency Services for an Emergency Medical Condition, and post-stabilization services provided as part of outpatient observation or an inpatient or outpatient stay with respect to the visit where Emergency Services were furnished, are described in Section 3.04. .

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 Provider 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 or the next working day of receiving the service (whichever is later). Follow-up care must be provided by a Participating Physician in order to be a Covered Service.

1.14 Prosthetics and Durable Medical Equipment

Coverage is provided for prosthetic devices and Durable Medical Equipment. If more than one item can meet your functional needs, benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, we will only pay the amount that we would have paid for the items that meet 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 item. Services related to the repair or replacement of an item are only considered necessary when due to a change in the Member's medical condition. A penile prosthesis will be considered for benefit only after prostate Surgery. Replacement of items due to damage or wear and tear are not covered.

Authorization is required before you get the DME if the purchase price or rental cost is $500 or more. In addition, supplies used with the DME must be Authorized every 90 days. If Authorization is not obtained, no benefits will be provided for the DME or the supplies.

1.15 Medical Supplies

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

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

Supplies and equipment that have non-therapeutic uses, over-the-counter supplies and bandages are not Covered Services.

1.16 Dental Care for Accidental Injury

Dental services performed by a Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.) to sound natural teeth required because of Accidental Injury are Covered Services. No benefits are provided for injuries that occur while the Member is in the act of chewing or biting. Only services directly related to the accidental injury are Covered Services. No Coverage is provided unless the dentist certifies to BlueChoice that services were performed to sound natural teeth that were injured as a result of an accident, and that the services were completed within six months of the accident.

1.17 Benefits Mandated by State and/or Federal Law

1. **Preventive Care Services.** Notwithstanding anything herein to the contrary, coverage is provided, without cost-sharing, for the preventive services described in Section 1.17, when furnished by a Participating Provider.

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

3. **Hospitalization for Mastectomies.** Coverage is provided for hospitalization for at least 48 hours following the mastectomy. In the case of an early release, Coverage shall include at least one home care visit if ordered by the attending Physician. Benefits are provided on the same basis as any other condition or illness.

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

    A. Once as a base-line mammogram for a female who is at least 35 years of age but less than 40 years of age;
    B. Once every two years for a female who is at least 40 years of age but less than 50 years of age;
    C. Once a year for a female who is at least 50 years of age; or
    D. In accordance with the most recently published guidelines of the American Cancer Society. The American Cancer Society is an independent organization that offers health information and recommendations; it is not affiliated with BlueChoice.

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

6. **Prostate Examinations.** Coverage is provided for prostate cancer examinations, screenings and laboratory work for diagnostic purposes in accordance with the most recently published guidelines of the American Cancer Society.

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

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

8. **Cleft Lip and Palate**

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

   A. Oral and facial surgery, surgical management and follow-up care
   B. Prosthetic treatment such as 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 Certificate. Benefits are provided on the same basis as for any other medical condition or illness as specified in the Schedule of Benefits.

9. **Autism Spectrum Disorder.**

   Benefits will be paid for ABA related to Autism Spectrum Disorder as set forth on the Schedule of Benefits.

   Services must be provided by or under direction of an approved Participating Provider**.**

1.18 Preventive Services

A limited number of services are provided as preventive care with no cost sharing. Benefits will be provided as follows:

- The United States Preventive Services Task Force (USPSTF) recommended Grade A or B screenings

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
- Screenings recommended for children and women by Health Resources and Services Administration (HRSA)
- Preventive prostate screenings and lab work according to the American Cancer Society (ACS) guidelines
- Pediatric oral and vision care as recommended by the United States Preventive Services Task Force (USPSTF) Grade A or B screenings and Health Resources and Services Administration (HRSA)
- Any item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019 (COVID-19) and that is, with respect to the individual involved (1) an evidence-based item or service that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force, or (2) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (regardless of whether the immunization is recommended for routine use).

Multitargeted stool DNA testing (FIT-DNA) must meet BlueChoice's medical guidelines and/or policies in order to be covered.

These services are covered In-Network only. Preventive care must meet the age and/or condition guidelines/recommendations of the USPSTF, ACIP, CDC, HRSA or ACS to be covered at no cost to the Member. These organizations and agencies are independent organizations that offer health information and recommendations; they are not affiliated with BlueChoice.

1.19 Clinical Trials

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.

1.20 Vision Care

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

1.21 Diabetes Education and Preventive Care

Diabetes education and preventive care received from a Participating Provider.

1.22 Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield 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 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 below.

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") do not contract with the Host Blue. We explain below how we pay both kinds of providers.

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 Covered 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.

When you receive Covered Services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services 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 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.

Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to us through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If we have entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to employer on your behalf, we will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

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

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.

C. Nonparticipating Providers Outside Our Service Area (Optional)

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

D. Blue Cross Blue Shield Global® Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), 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 BlueCard service area in certain ways. For instance, although 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 BlueCard service area, 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 BlueCard service area, 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, can 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 BlueCard service area 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.

1.23 Discount Services

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

1.24 Varicose Vein

Benefits will be provided for the treatment of varicose veins, when the services are received from a Participating Provider. A Participating Provider must be a center or office accredited by the Intersocietal Accreditation Commission. Covered services will be limited to $5,000 per member per lifetime.

1.25 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).

1.26 Pain Management Program

We may, in accordance with our medical guidelines, 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.

SECTION 2
PROCEDURES FOR OBTAINING BENEFITS

With BlueChoice Advantage Plus, you have benefits for Covered Services provided by any licensed healthcare professional. For coverage at the In-Network benefit level, unless otherwise specified, services must be received from a Participating Provider. Or, you may see a healthcare professional who is not in the BlueChoice network and generally receive benefits for Covered Services at the lower, Out-of-Network level. Some services may not be Covered if you receive them from an Out-of-Network Provider – a Non-Participating Provider. Please refer to your Schedule of Benefits and Section 1 of this Certificate for additional details**.**

2.01 Verification of Participation Status

You are responsible for verifying the participation status of the Physician, Hospital, or other Provider prior to receiving Covered Services. You may verify participation status by contacting Member Services through the website at www.BlueChoiceSC.com/findcare, or by calling 803-786-8476 in Columbia or 800-868-2528 when outside the Columbia area.

Enrolling for coverage under BlueChoice Advantage Plus 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.

2.02 Continuation of Care

If benefits under this Certificate 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 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 receive Network benefits for that Provider's services for limited period of time. We will attempt to notify you 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 to receive the continued Network coverage.

We recommend you use a form for this request. This form can be found by going to the website at www.BlueChoiceSC.com or calling the Member Service phone number on your BlueChoice ID card. Your treating Physician should include a statement on the form 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, we will provide In-Network Benefits for you 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 Contract, including regular benefit limits.

2.03 Referral Health Services by Non-Participating Providers

If specific Covered Services cannot be provided by or through a Participating Provider, you may be eligible for Coverage at the In-Network benefit level for Covered Services obtained through non-Participating Providers. These services must be authorized in advance and provided at a Provider designated by BlueChoice and are

subject to the provisions, limitations and exclusions of this Contract. It is your responsibility to obtain this required authorization prior to receiving the services.

2.04 Prior Authorization

The following items require prior Authorization in order for any benefits to be covered:

- All Inpatient Admissions, except for Emergency Admissions
  - For emergency admissions, you or someone acting on your behalf must notify BlueChoice no later than 24 hours after the admission or the next working day, whichever is later.
- Continued Inpatient Admissions.
- Outpatient facility admissions, except for Emergency Admissions
  - For emergency admissions, you or someone acting on your behalf must notify BlueChoice no later than 24 hours after the admission or the next working day, whichever is later.
- All Inpatient, Outpatient/office psychological testing, Intensive Outpatient and/or Partial Hospitalization programs, Repetitive Transcranial magnetic Stimulation (rTMS) and Electroconvulsive therapy and certain Prescription Drugs for Behavioral Health Disorders. Prior Authorization requests and treatment plans must be approved by CBA.
- Autism Spectrum Disorder treatment. Prior Authorization requests and treatment plans must be approved by CBA.
- Dental Services to Sound Natural Teeth Related to Accidental Injury after initial visit.
- Habilitation Services.
- Home Health Services.
- Hospice Services.
- Covered transplants, which must be obtained from a Provider designated by BlueChoice.
- DME that has a purchase price or rental cost of $500 or more. Any supplies used with DME must be Authorized every 90 days.
- Virtual colonoscopies, subject to medical management guidelines.
- Treatment of varicose veins.
- Services, supplies, or charges for a covered multi-disciplinary Pain Management Program, regardless of the state of location of the provider.
- Prescription Drugs as listed in the Prescription Drug List.
- Cardiac rehabilitation.
- Pulmonary rehabilitation.
- Dialysis.
- Radiation oncology.
- Injectable/infusible chemotherapy.
- Treatment of hemophilia
- Advanced radiology.
- Nuclear cardiology.
- Musculoskeletal care.
- Home infusion therapy.
- Home occupational therapy
- Home physical therapy.
- Home speech therapy.
- Biofeedback.

2.05 Concurrent Review

BlueChoice will conduct concurrent review of all Inpatient admissions. Each requested extension will be reviewed on a case-by-case basis. If and to the extent that the continued treatment is not approved, benefits may be denied for the continued portion of the treatment/stay. Network Providers in South Carolina are responsible for providing information relating to the concurrent reviews.

2.06 Authorization Does Not Guarantee Benefits

The fact that BlueChoice authorizes services or supplies does not guarantee that all charges will be Covered. Benefit determinations are made by BlueChoice in accordance with all of the terms, conditions, limitations and exclusions of this Contract, including eligibility.

2.07 Services Outside of South Carolina -The BlueCard® Program

Follow these easy steps for health coverage when you are away from home in the United States:

1. Always carry your current BlueChoice ID card.
2. In an Emergency, go directly to the nearest Hospital.
3. To find names and addresses of nearby doctors and Hospitals, visit www.BlueChoiceSC.com/findcare or call BlueCard Access at 1-800-810-BLUE. This phone number can also be found on your Member identification card.
4. If you are admitted to the Hospital, call BlueChoice for prior Authorization. (Refer to the phone number on the back of your BlueChoice ID card)
5. When you arrive at the participating doctor's office or Hospital, simply present your BlueChoice ID card. As a BlueChoice Advantage Plus Member, the doctor will recognize the PPO℠ logo.

After you receive care:

- You should not have to complete any claim forms.
- You should not have to pay up front for medical services other than the usual out-of-pocket expenses (non-Covered Services, Deductible, Copayment and Coinsurance).
- BlueChoice will send you an Explanation of Benefits.

You also have coverage when you are traveling outside the United States. Please call BlueChoice before you leave for additional information.

SECTION 3
HOW TO FILE A CLAIM

3.01 Participating Providers

Participating Providers have agreed with BlueChoice to do the following:

1. File all claims for Covered Services directly to BlueChoice
2. Collect only the Copayment, Deductible and Coinsurance amounts, if any, for Covered Services. These amounts, which are part of the charge for Covered Services that you pay, are shown in the Schedule of Benefits
3. Accept the Fee Schedule (minus any applicable Coinsurance, Copayment or Deductible) as payment in full for Covered Services.

If you are billed by a Participating Provider for other than any applicable Coinsurance, Copayment or Deductible, you should contact BlueChoice.

3.02 Non-Participating Providers

In many cases, Non-Participating Providers can bill you for charges in excess of the amount that BlueChoice reimburses in accordance with the applicable terms of this Certificate (and Member Cost Sharing, if applicable).

Benefits payable under the Contract are not assignable to a non-Participating Provider. This means BlueChoice may send benefit payments to you and you will be responsible for paying the non-Participating Provider, unless and to the extent that BlueChoice is required under applicable law, or chooses in its discretion, to send such payments directly to a non-Participating Provider on your behalf.

3.03 Prescription Medication Expenses

When your Physician prescribes medication, be sure to have it filled at a Participating Pharmacy. No coverage is provided for non-Participating Pharmacies. Show the pharmacist your ID card so that the claim can be filled electronically for you.

You can find Participating Network Pharmacies by going to our online Provider directory at www.BlueChoiceSC.com/member-center/advantage-plus-plan.

3.04 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 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 Share amounts under all other terms of this coverage. These are the only circumstances in which BlueChoice will allow for Out-of-Network services without 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 with respect to the Emergency department visit where Emergency Services were furnished. In Emergency situations, no prior Authorization is required. For post-stabilization services, the Provider or Facility may furnish you a notice of treatment by a non-Network

Provider and an opportunity to consent to the treatment, in which case this Section 3.04 will not apply to those post-stabilization services.

- 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 and your surgeon is In-Network, but the anesthesiologist is Out-of-Network. Except for certain ancillary services, and other items and services furnished due to unforeseen, urgent medical needs, the Provider may furnish you a notice of treatment by a non-Network Provider and an opportunity to consent to the treatment, in which case this Section 3.04 will not apply to those services.
- 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."

SECTION 4
WHAT IS NOT COVERED

4.01 Exclusions

No benefits are provided for the following unless otherwise specified in the Schedule of Benefits. Treatment of an injury which is generally covered by this contract, will not be denied if the injury results from an act of domestic violence or a medical condition (including both physical and mental conditions), even if the medical condition was not diagnosed before the injury.

1. Services, supplies or Prescription Drugs for which you are entitled to benefits under Medicare or other governmental program as the primary payer, except Medicaid; or for which the Member is not legally obligated to pay.

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

3. Any services or supplies for which benefits are paid by Workers' Compensation or settlement of a Workers' Compensation claim, occupational disease law or other similar legislation.

4. Any loss that results from you committing or attempting to commit a crime, whether felony or misdemeanor, or from engaging in an illegal occupation; treatment of an injury or illness due to voluntary participation in a riot or uprising.

5. Any charges for services provided prior to the Member's Effective Date or after the termination of Coverage, except as described in the *Extended Benefits for Total Disability* section of this Certificate.

6. Admissions or portions thereof for Long-Term Care, including 1) rest care; 2) care to assist a Member in the performance of activities of daily living (including but not limited to walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication); 3) custodial or Long-Term Care; or; 4) therapeutic schools, wilderness/boot camps, therapeutic boarding homes, halfway houses and therapeutic group homes (this exclusion does not apply to otherwise Covered Services furnished in these settings).

7. Medical supplies, services or charges for the diagnosis or treatment of learning disorders, communication disorders, motor skills disorders, relational problems, intellectual disabilities and vocational rehabilitation, except as specified on the Schedule of Benefits.

8. Counseling and psychotherapy services for the following conditions are not covered: 1) TIC disorders, except when related to Tourette's disorder, 2) mental disorders due to a general medical condition, 3) medication induced movement disorders, or 4) nicotine dependence, except when a part of an approved wellness program.

9. All admission to Hospitals or free-standing Rehabilitation Facilities for physical rehabilitation when the services are not furnished at a Provider we designate and/or the Member does not receive the required Authorization.

10. Any behavioral, educational or alternative therapy techniques to target cognition, behavior, language and social skills modification, including:
    a. Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs.
    b. Higashi schools/daily life.
    c. Facilitated communication.
    d. Floor time.
    e. Developmental Individual-Difference Relationship-based model (DIR).
    f. Relationship Development Intervention (RDI).
    g. Holding therapy.
    h. Movement therapies.
    i. Primal therapy.
    j. Group socialization.
    k. Art therapy.
    l. Music therapy.
    m. Animal-assisted therapy.

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

12. All services and supplies related to pregnancy of a Dependent child except for life-threatening complications of pregnancy to either the mother or the fetus and mandated preventive care. An elective abortion is not considered to be a complication of pregnancy.

13. Any services, supplies or drugs for the diagnosis or treatment of infertility. This includes but is not limited to lab and X-ray tests, artificial insemination and in-vitro fertilization; fertility drugs; reversal of sterilization procedures; and surrogate parenting.

14. Preconception testing or preconception genetic testing.

15. Any drugs, services, treatment or supplies determined by BlueChoice medical staff, with appropriate consultation, to be Experimental or Investigational Services. NOTE: Benefits may be provided for off-label uses of pharmaceuticals that have been approved by the US FDA (but not approved for the prescribed use) provided that the drug is not contraindicated by the FDA for the off-label use prescribed, and that the drug has been proven safe, effective and accepted for the treatment of the specific medical condition for which the drug has been prescribed, as evidenced by the results of good quality-controlled clinical studies published in at least two peer reviewed full length articles in respected national professional medical journals.

16. All vitamins, except prenatal vitamins due to pregnancy or otherwise covered as preventive care and purchased at a Participating Pharmacy; drugs not approved by the Food and Drug Administration; drugs for the treatment of non-Covered therapies, services, or conditions such as drugs prescribed for obesity or weight control, cosmetic purposes, hair growth, fertility, or sexual dysfunction.

17. Services and supplies related to cosmetic Surgery, as determined by us, unless otherwise required to be covered by this Certificate, the Schedule of Benefits, or applicable law. This means any plastic or reconstructive Surgery done mainly to improve the appearance of any body part and from which no improvement in physiologic function is reasonably expected, unless performed either to correct functional disorder or as a result of an injury. Excluded cosmetic Surgery includes but is not limited to:

- Surgery for sagging or extra skin
- Any augmentation, reduction, reshaping or injection procedures
- Rhinoplasty, abdominoplasty, liposuction and other associated Surgery
- Any procedures using an implant that doesn't alter physiologic function or isn't incidental to a surgical procedure.

Any services a Member receives due to complications of cosmetic Surgery are not covered.

18. Biofeedback, unless Authorized in accordance with our medical guidelines.

19. Services or supplies related to dysfunctional conditions of the chewing muscles, wrong position or deformities of the jawbone(s), orthognathic deformities or temporomandibular joint syndrome (headache, facial pain and jaw tenderness caused by jaw problems and usually known as TMJ).

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

    - An operation or treatment for the fitting or wearing of dentures, regardless if needed due to injury of natural teeth due to an accident;
    - Orthodontic care or treatment of malocclusion;
    - Operations on or treatment of or to the teeth or supporting bones and/or tissues of the teeth except for removal of malignant tumors or cysts;
    - Any treatment of an injury to natural teeth due to an accident not received within 6 months of the accident date; injuries incurred while the Member is in the act of chewing or biting is not covered;
    - Removal of teeth, whether impacted or not; and
    - Any operation, service, prosthesis, supply or treatment for the preparation for, and the insertion or removal of a dental implant.

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

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

22. Charges incurred as the result of a missed scheduled appointment and charges for the preparation, reproduction, or completion of medical records, itemized bills, or claims forms. Physician charges for virtual office visits including but not limited to telephonic, internet, electronic mail or video chat consultations, except to the extent otherwise provided in this Certificate or, Schedule of Benefits.

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

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

25. Items purchased that exceed the minimum specifications for the Member's needs. We will pay only the amount that we would have paid for the items that meets the Member's minimum specifications. The Member will be responsible for any difference in the cost.

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

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

28. Services or care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of such nerve interference, where such interference is the result of or related distortion, misalignment or subluxation of, or in, the vertebral column.

29. 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 Pain Management Program described under the Covered Services section of this Certificate.

30. Any treatment or Surgery for obesity (even if morbid obesity is present), weight reduction or weight control, such as but not limited tore gastric bypass, insertion of stomach (gastric) banding, intestinal bypass, wiring mouth shut, or liposuction, 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 Covered Services section of this Certificate. In addition, complications from these non-covered procedures are also not covered. 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.

31. Orthomolecular therapy including infant formula, nutrients, vitamins and food supplements, even if the Physician orders or prescribes them. Enteral feedings when not a sole source of nutrition.

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

33. Services and supplies related to non-surgical treatment of the feet, except non-FDA-approved technologies for non-surgical foot treatment related to diabetes.

34. Nutrition counseling, lifestyle improvements, or physical fitness programs.

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

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

37. Services, supplies or treatment for venous incompetence and/or varicose veins, including but not limited to endovenous ablation, vein stripping, or the injection of sclerosing solutions, unless otherwise provided in this Certificate or the Schedule of Benefits.

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

39. Pulmonary Rehabilitation, except in conjunction with a lung transplant.

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

41. Any service (other than Substance Use Disorder Services), Medical Supplies, charges or losses resulting, from, in whole or in part, directly or indirectly, and/or contributed to, by a Member being Legally Intoxicated or under the influence of alcohol, and drug or other substance or taking some action the purpose of which is to create a euphoric state or alter consciousness. The Member, or Member's representative, must provide any available test results showing blood alcohol and/or drug/substance levels upon request by us. If a Member refuses to provide these test results, no benefits will be provided.

42. Services provided for home birth.

43. Services by a Home Health Aide.

44. Repair, replacement or duplicates of Durable Medical Equipment/Prosthetics, except when Medically Necessary due to a change in the Member's medical condition and Authorized by us. Repair or replacement for routine wear and tear is not covered.

45. Durable Medical Equipment when you don't get the required Authorization and any charges in excess of the purchase price.

46. Services, supplies and equipment that have non-therapeutic uses or that are available over the counter, such as but not limited to air conditioners, whirlpool baths, spas, (de)humidifiers, wigs, fitness supplies, vacuum cleaners or air filters and common first aid supplies, even with a Prescription.

47. Bionic/bioelectric, microprocessor or computer-programmed prosthetic components.

48. Admissions or portions thereof for long-term or chronic care medical or psychiatric conditions, except when Medically Necessary and approved by us.

49. Treatment resulting from war or acts of war (whether declared or undeclared) or while in the military service or its auxiliary units.

50. Services or supplies a Member received from any intentionally self-inflicted injury (or injury resulting from attempted suicide) unless it results from a medical (physical or mental) condition, even if the condition is not diagnosed prior to the injury.

51. Investigational or Experimental Services, as determined by us, including but not limited to the following:

    Relating to transplants:
    - Uses of allogeneic bone marrow transplantation (between two related or unrelated people) or syngeneic bone marrow transplantation (from one identical twin to the other) along with other forms of stem cell transplant (with or without high doses of chemotherapy or radiation) in cases in which less than four of the six complex antigens match; cases in which mixed leukocyte culture is reactive and AIDS and HIV infection
    - Adrenal tissue to brain transplants

- Islet cell transplants
- Procedures that involve the transplantation of fetal tissues into a living recipient.

Relating to other conditions or services:

- Dorsal rhizotomy (cutting spinal nerve roots) in the treatment of spasticity (increased tone or tension in a muscle such as a leg)

52. Services and supplies related to transplants involving mechanical or animal organs, human organ and/or tissue transplant procedures when the required Authorization is not obtained, or when the services are not performed at a Blue Distinction Centers for Transplant Designation, or unless specifically provided otherwise in this Certificate, the Schedule of Benefits, or applicable law.

53. Reduction mammoplasty for macromastia unless the Member is within 20 percent of the recommended body weight in accordance with BlueChoice's medical guidelines.

54. Home health care and hospice services, except to the extent provided in Section 1: What's Covered.

55. Physician charges for drugs, appliances, supplies, blood and blood products.

56. Telemonitoring, telehealth and telemedicine except as provided herein or shown in the Schedule of Benefits or What's Covered.

57. Replacement of Prosthetic Devices due to damage or wear and tear.

58. Luxury or convenience items whether or not a Physician recommends or prescribes them.

59. Any and all travel expenses (including those related to a transplant), such as but not limited to immunizations required prior to travel, transportation, lodging and repatriation unless specifically included in the What's Covered section of the Certificate.

60. Routine, non-Emergency ambulance 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 a sub-acute place of care such as a Skilled Nursing Facility.

61. Services, procedures, charges, supplies, equipment or pharmaceuticals for which Preauthorization is required and not obtained.

62. Services and supplies that are not Medically Necessary, not needed for the diagnosis or treatment of an illness or injury, or not specifically listed in Covered Services.

63. Prescription Drugs and pharmaceuticals under the medical portion of this coverage when benefits are available under the Prescription Drug benefit.

64. The following Prescription Medications and/or Specialty Drugs:

- That are used for or related to non-Covered Services or conditions, such as but not limited to weight control, obesity, erectile dysfunction, cosmetic purposes (such as Tretinoin or Retin-A, Kybella for chin fat), hair growth and hair removal. Also excludes all vitamins (except for prenatal vitamins due to pregnancy or otherwise covered as Preventive Care and purchased at a Participating pharmacy).
- That are used for infertility.
- That are more than the number of days' supply allowed as shown in Covered Services.
- That are for refills in excess of the number specified on your Physician's prescription order.
- That are for more than the recommended daily dosage defined by BlueChoice unless prior Authorization is sought and approved.
- Drugs that are not provided in compliance with any applicable place of service requirements.
- That are available over the counter or when there's an over-the-counter drug equivalent containing the same active ingredients as the prescription version, including any over-the-counter supplies, devices or supplements.
- When not consistent with the diagnosis and treatment of an illness, injury or condition or when excessive in terms of the scope, duration or intensity of drug therapy that's needed to provide safe, adequate and appropriate care.
- That are medications classified as self-administered drugs when obtained, purchased and/or administered at a doctor's office or in an Outpatient setting.
- That require Authorization and the Authorization is not received.
- That require step therapy when a Step Therapy Program is not followed.
- That are received Out-of-Network, unless due to an Emergency Medical Condition that is treated at an Urgent Care Center, Hospital Emergency department, or free-standing Emergency department.
- That are not on the Prescription Drug List.
- That are medications or drugs for which some or all of the Cost Sharing is paid by a drug manufacturer in any form of direct support (cash, reimbursement, coupon, voucher, debit card, etc.) that reduces or eliminates immediate out-of-pocket costs for a specific prescription brand drug. Although the drug remains a covered prescription drug, Cost Sharing amounts provided by the drug manufacturer will not be counted toward the Member's annual limitation on Cost Sharing.
- That are new to the market and under clinical review by BlueChoice, and which are therefore listed on the Prescription Drug List as excluded until the clinical review has been completed and a final determination has been made as to whether the drug should be covered.
- That are Prescription Drugs and pharmaceuticals that could be covered under the both the medical and Prescription Drug portion of this coverage. In that case, coverage is provided under the Prescription Drug benefit only.

65. Separate charges for services or supplies from an employee of a Hospital, laboratory or other institution, or an independent health care professional whose services are normally included in facility charges.

66. Any type of fee or charge, for handling medical records, filing a claim or missing a scheduled appointment.

67. Any service or treatment for complications resulting from any non-covered procedure or condition.

68. Diabetes education and preventive care received from an Out-of-Network Provider.

69. Any Covered Services provided in excess of an applicable limit described in this Certificate or the Schedule of Benefits.

70. Services, procedures, charges, supplies, equipment or pharmaceuticals for which Authorization is required and not obtained.

71. 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.

4.02 Limitation

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

SECTION 5
WHEN COVERAGE BEGINS

5.01 Eligibility

1. Every Employee within the class(es) set forth 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 Waiting Period, if applicable. The Employee must be determined by the Employer and communicated to BlueChoice to 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 days noted in item 1. 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.

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

   Meet the Employer's eligibility requirements for Dependent coverage and either:
   A. Be the Subscriber's legal spouse; or
   B. Be the Subscriber's natural child, adopted child, foster child, stepchild, or child for whom the Subscriber has legal custody or legal guardianship. The child must be less than 26 years of age (unless otherwise specified on the Master Group Application), unless the child of the Subscriber is an Incapacitated Dependent.

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

4. A Dependent child who otherwise is eligible for coverage shall not be denied enrollment for any of the following reasons: the child was born out of wedlock; the child is not claimed as a dependent on the Subscriber's federal tax return; the child does not reside with the Subscriber; or the child does not reside in the Local Service Area.

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

5.02 Election of Coverage

Any Employee eligible for coverage on the Contract Effective Date may elect coverage for himself or herself and any eligible Dependents by completing and filing with the Employer a Membership Application during the initial enrollment period specified in the Master Group Contract. In addition, new Employees may enroll within 31 days of the date they first become eligible for coverage. Dependents may be enrolled within 31 days of the date on which they first become Dependents. Persons also may enroll if eligible during a Special Enrollment Period.

5.03 Effective Date of Coverage

Unless otherwise provided in this Certificate, the Master Group Contract or the Master Group Application, coverage shall commence as stated in this section. In all cases, the required premium must be paid before Coverage begins.

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

2. For an Employee eligible prior to and on the Contract Effective Date who elects coverage, coverage begins on the Contract Effective Date if a Membership Application is submitted prior to the Contract Effective Date and the Employee is Actively-at-work.

3. For an Employee who becomes eligible after the Contract Effective Date and who elects coverage, coverage begins on the first day of the next month following such eligibility and election. This date will be the Member's Effective Date, provided the Membership Application is received by BlueChoice prior to the Member's Effective Date and the Employee is Actively-at-work.

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

5. For an adopted child of the Employee:

   A. Coverage shall be retroactive from the moment of birth for a child with respect to whom a decree of adoption by the Employee has been entered within 31 days after the date of the child's birth;
   B. if adoption proceedings have been instituted by the Employee within 31 days after the date of the child's birth and the Employee has temporary custody, coverage shall be provided from the moment of birth;
   C. for adopted children other than a newborn, coverage shall commence upon temporary custody and will continue as long as the Employee has custody.

5.04 Special Enrollment Periods

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

1. The person had covered under a Group Health Plan or Health Insurance Coverage at the time enrollment was previously offered and each of the following applies:
   a. The Employee stated in writing at the time that coverage under a Group Health Plan or Health Insurance Coverage was the reason for declining enrollment, but only if BlueChoice required such a statement at the time and provided the Employee with notice of the requirement and the consequences of the requirement at the time.
   b. The Employee's or Dependent's coverage:
      i. Was under a COBRA continuation coverage provision and the coverage has exhausted; or
      ii. Was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or employer contributions toward the coverage were terminated.

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

The following apply to a Dependent Special Enrollment Period:

3. A. If a Group Health Plan makes Coverage available for a dependent of an individual, and
   B. The individual is a participant under the plan, or has met any Waiting Period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period, and
   C. The person becomes a dependent of the individual through marriage, birth, or adoption or placement for adoption, then
   D. The health insurance issuer offering Health Insurance Coverage in connection with the Group Health Plan shall provide for a Dependent Special Enrollment Period during which the person may be enrolled under the plan as a Dependent of the individual. In the case of the birth or adoption of a child, the spouse of the individual may be enrolled as Dependent of the individual if such spouse is otherwise eligible for Coverage.

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

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

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

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

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

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

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

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

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

SECTION 6
WHEN COVERAGE ENDS

6.01 Conditions for Termination of a Member's Coverage Under the Contract

Subject to continuation and conversion privileges stated in this section, coverage of the Member, including Covered Services provided after the date of termination for medical conditions arising prior to the date of termination, shall automatically terminate on the earliest of the dates specified below.

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

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

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

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

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

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

7. The date the Subscriber dies.

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

If an enrolled Employee is no longer working an average of 30 hours per week, including paid, or is no longer on an approved leave of absence equal to or less than 90 days (or beyond 90 days if protected by applicable law) and has not returned to work, coverage for that Employee and any enrolled Dependents will end.

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

Under certain circumstances, Members who cease to be eligible for coverage under the Contract may be eligible to continue coverage under the Contract or to convert to another policy. Members should refer to the following subsections for additional details.

6.02 Payment and Reimbursement Upon Termination

Termination of the Contract shall not affect any request for reimbursement for Covered Services received prior to the effective date of termination, when such request is furnished as required in Section 4, How to File a Claim, of this Certificate.

6.03 Extended Benefits for Total Disability

1. If coverage under this Contract is terminated under this section, all rights to receive benefits provided in this Contract on the date of such termination shall automatically cease, except as otherwise provided in this Certificate or elsewhere in the Contract, except that an Employee or Dependent confined to a Hospital, Long-Term Acute Care Facility, Rehabilitation Hospital, Skilled Nursing Facility or Residential Treatment Facility or is totally disabled on the date of such termination is entitled to receive benefits specified in sections 1 and 2, for each day of that Admission or total disability. Benefits are subject to all exclusions, limitations, Coinsurance, Copayments and Deductibles stated in this Contract including the Schedule of Benefits. Benefits provided are limited to services directly related to the illness or injury causing the confinement or the total disability. In all situations except BlueChoice's withdrawal from the large group market, the extension of benefits liability of BlueChoice under this section ends at the earliest of:

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

2. As used in this paragraph with respect to an Employee, the terms "totally disabled" and "total disability" mean disability to the extent that the Employee is receiving ongoing medical care by a Physician and is unable to perform any of the usual and customary duties of his/her own employment or occupation during the first year of disability or for the length of the benefit period if less than one year. After the first year of disability, total disability is defined as the complete inability of the Employee to engage in any employment or occupation, for wage or profit, for which the Employee is qualified by reason of education, training or experience. With respect to a Dependent, the terms mean disability to the extent that the Dependent is receiving ongoing medical care by a Physician and is unable to perform any of the usual and customary duties or activities of a person in good health of the same age and sex.

Important Note: The Member must notify BlueChoice within 12 months if they wish to exercise the Extended Benefits for Total Disability rights. BlueChoice will then determine if the Member is eligible for the benefits. Premium payments are waived for Members receiving Extended Benefits for Total Disability. There are no continuation rights or any conversion rights available to any Member at the end of the Extended Benefits period.

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

6.04 Continuation Coverage Under Federal Law (COBRA)

A Member whose coverage would otherwise end under the Contract may be eligible to elect continuation coverage in accordance with federal law under COBRA (Consolidated Omnibus Budget Reconciliation Act) or continuation coverage in accordance with state law. Continuation coverage under COBRA applies only to Employers that are subject to the provisions of COBRA. Members should contact the Employer's human resources department to determine if he or she is eligible to continue coverage under COBRA.

6.05 Continuation Coverage Under State Law

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

6.06 Conversion Privilege for A Former Spouse

In addition to COBRA continuation coverage rights, an enrolled Dependent who ceases to be eligible due to divorce from the Subscriber will be able to purchase another policy from BlueChoice without evidence of insurability and upon Application made to BlueChoice within 60 days following the decree of divorce, and upon payment of the appropriate premium. The new policy will be a policy that complies with the Affordable Care Act provisions. Any probationary or Waiting Periods set forth in the Certificate, Master Group Application, or Schedule of Benefits shall be considered as being met to the extent coverage was in force under the prior policy.

SECTION 7
COORDINATION OF BENEFITS AND SUBROGATION

7.01 Purpose of Coordination of Benefits (COB)

A person may be covered for benefits under more than one health plan. In this case, BlueChoice will coordinate benefits with the other plans to prevent duplicate payments and overpayments. The benefits under this Contract plus any benefits due from other group coverage, will not exceed the amount of actual expenses charged for services. If a person's other group coverage is responsible for making payments first, BlueChoice cannot pay until information is provided concerning how much the other coverage paid. The person must report to BlueChoice any other group benefit plan for which the person is eligible.

The rules determining which group coverage should pay primary (first) are as follows using the first of the following rules that applies:

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

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

3. **Dependent Child and Parents Separated or Divorced**. In the case of divorce or legal separation, the plan that should pay primary for the child is determined in the following order:

    A. the plan of the parent with custody of the child.
    B. the plan of the spouse of the parent with the custody of the child.
    C. the plan of the parent not having custody of the child.
    D. If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first.
    E. If the specific terms of a court decree state that the parents shall share joint custody without specifying that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the rules in paragraph 2 of this section.

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

5. **Longer or Shorter Length of Coverage**. If a person works at several places and each place has a Group Health Plan, the plan he or she has been covered under the longest is primary.

6. **Continuation Coverage** - If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

    A. First, extended benefits payable under the continuation coverage
    B. Second, the benefits of a plan covering the person as an Employee, Member, or Subscriber (or as that person's Dependent)

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

When a Group Health Plan does not have a coordination of benefits provision, that plan is primary.

7.02 Effect on the Benefits of this Plan

1. **When This Section Applies**. This Section 7.02 applies when, in accordance with Section 7.01, this plan is a secondary plan as to one or more other plans. In that event, the benefits of this plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in paragraph 2.B. immediately below.

2. **Reduction in This Plan's Benefits**. The benefits of this plan will be reduced when the sum of A and B below exceeds those allowable expenses in a claim determination period:

   A. Benefits payable for the allowable expense under this plan in the absence of this COB provision
   B. Benefits payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made.

   In such case, the benefits of this plan are reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

   When the benefits of this plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

3. If this Contract would be secondary to Medicare as provided under federal law, and if the Member did not elect to enroll in Medicare, benefits under this Contract may be reduced by the amount that would have been paid by Medicare had the Member elected such coverage.

7.03 Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. BlueChoice has the right to decide what information is needed in order to apply these COB rules. Such information may be obtained from or given to any other entity or person without the consent of any person. Each person claiming benefits under this plan must give BlueChoice any facts necessary to administer the benefits of this plan.

7.04 Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. In such event, BlueChoice may pay that amount to the entity that made such payment. That amount will then be treated as though it were a benefit paid under this plan. BlueChoice will not pay that same amount again for the same claim. Payment made includes the reasonable cash value of any benefit provided in the form of services.

7.05 Right of Recovery

If the amount of the payment made under this plan is more than permitted under this COB provision, BlueChoice may recover the excess from one or more of:

1. the person(s) paid or person(s) for whom payment was made
2. insurance companies
3. other entities

The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

7.06 Subrogation

If you receive medical benefits under this coverage for an injury caused by the act or omissions of a liable third party and receive a settlement, judgment or other payment relating to the injury from a liable third party, any other person, firm, corporation, organization or business entity, you agree notify BlueChoice as soon as possible, and reimburse us for benefits that we've paid relating to the injury. BlueChoice has an equitable lien in connection with such benefits, and you or your legal representative must hold any recovered funds in trust or in a segregated account for our benefit until our subrogation and reimbursement rights are fully determined and satisfied. This agreement is a condition to receiving benefits under this coverage. Our right to subrogation or reimbursement applies to any judgment and/or settlement proceeds, whether or not liability is admitted.

Our interest in subrogation or reimbursement extends to all benefits relating to your injury, even if claims for those benefits haven't been submitted to us for payment at the time you receive the settlement, judgment or payment.

You have the right to petition the Director of Insurance or his designee to determine if our subrogation action is inequitable or unjust. If the Director makes the determination that allowing subrogation is inequitable or unjust, then it isn't allowed. This determination by the Director may be appealed to the Administrative Law Judge Division as provided by law.

We'll pay attorney fees and costs from the amount recovered.

If you choose not to pursue an action to recover damages, you agree to transfer all rights to recover damages in full for such benefits to us. At our expense, we lawfully stand in your place to recover the amount of money we've paid for your medical benefits from any third party who's liable, responsible or otherwise makes a payment for your injury. We may seek recovery for our payment of claims from the liable third party, any liability or other insurance covering the liable third party, or from your own uninsured motorist insurance and/or underinsured motorist insurance.

In all situations involving subrogation, you shall not do anything to hinder or slow our right to seek reimbursement. You shall cooperate with us, sign any documents, and do all things necessary to protect and secure our subrogation right.

Each time a claim is filed with a diagnosis that could be related to an accident or injury; you may receive a notice stating that we need information to complete processing the claim along with a questionnaire regarding the claim. For your files to be updated, you must return the questionnaire with the requested information.

If you receive a recovery but do not promptly segregate the funds and reimburse us in full of the funds, we will be entitled to take action to recover the reimbursement amount. This may include but not be limited to 1) initiating an action against the Member and/or the Member's attorney to compel compliance with this Section, 2) withholding or suspending benefits payable to or on behalf of the Member and the Member's Dependents until the Member complies or until the reimbursement amount has been fully paid to us, or 3) initiating other appropriate actions. If you do not reimburse us after receiving the recover, you will be responsible for paying us a reasonable interest rate on the reimbursement amount until we receive such reimbursement in full.

SECTION 8
REVIEWS AND APPEALS

8.01 Information and Records

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

The submission of a claim shall be deemed written proof of loss and written authorization from the Member to BlueChoice to obtain any medical or financial records and documents useful to BlueChoice. BlueChoice 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 BlueChoice in support of a Member's claim shall be deemed to be acting as the agent of the Member.

8.02 ERISA

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

8.03 Claims Processing

A. Initial Claims

1. Urgent Claims

An urgent claim is any claim for medical care or treatment where making a determination under the normal timeframes could seriously jeopardize your life or health or your ability to regain maximum function; or you would be subject to severe pain that could not adequately be managed without the care or treatment. We will defer to the attending Provider, or other Physician with knowledge of your medical condition, with respect to the decision as to whether a claim constitutes “Urgent Care.”

If your claim is determined to be an urgent claim, a notice will be sent as soon as possible, considering the medical exigencies, but in no case later than 72 hours after receipt of the claim. You may be given notice orally; in which case a written notice will be provided within three days of the oral notice. If your urgent claim is determined to be incomplete, you will be sent a notice to this effect within 24 hours of receipt of your claim, at which point you will have 48 hours to provide additional information.

If you request an extension of Urgent Care benefits beyond an initially determined period and make the request at least 24 hours prior to the expiration of the original determination, you will be notified within 24 hours of the receipt of the request.

2. Pre-Service Claims

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

We must give our decision on any pre-service claim, in writing or electronic form, within 15 calendar days.

An extension of 15 calendar days may be provided if we determine that, for reasons beyond our control, an extension is necessary. If an extension is required, we will notify you within the initial 15-day time period that an extension is necessary. When we require an extension due to incomplete information, we are entitled to the rest of the initial determination period to reach a benefit determination after the additional information is received form you or the Provider.

We will let you know within five calendar days if we receive incomplete information from you and additional information is required to make a determination. You have 60 calendar days to send us the required information. If we do not receive the required information within the 60-day time period, we may deny the claim.

3. Post-Service Claims

A post-service claim is a claim for services for which your benefits plan does not require Authorization.

When you submit a post-service claim and your claim is denied, a notice will be sent within a reasonable time period, but not longer than 30 days from receipt of the claim. If BlueChoice determines that an extension is necessary due to matters beyond the control of the plan, this time may be extended 15 days. You will be sent notice prior to the extension that indicates the circumstances requiring the extension and the date by which the plan expects to provide a determination. If the extension is necessary in order to request additional information needed to decide the claim, which you failed to submit previously, the extension notice will describe the required information, and you will be given 60 calendar days to submit the information.

4. Concurrent Care Claims

A concurrent care claim is a claim that arises when there is a reduction or termination of ongoing care.

You will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction so that you will be able to appeal the decision before the coverage is reduced or terminated, unless such a reduction or termination is due to a plan amendment or termination of your benefits plan.

5. Notice of Determination

If your claim is filed properly and is wholly or partially denied, you will be sent notice of an adverse benefit determination that will:

- State the specific reason(s) for the adverse benefit determination;
- Reference the specific plan provisions on which the determination is based;
- Describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary;
- Describe the plan's claims review procedures and the time limits applicable to such procedures, including information regarding how to initiate an appeal, and a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review, if you are enrolled in an ERISA plan;
- Disclose any internal rule, guideline, or protocol relied upon in making the adverse determination (or state that such information is available free of charge upon request);
- If the denial is based on medical necessity, experimental treatment or other similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);
- Include sufficient information to identify the claim, including the date of service, health care provider, claimant, and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;
- Include the denial code and its corresponding meaning; and
- Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

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

B. REQUEST FOR REVIEW AND APPEALS

You have 180 days from the receipt of an adverse benefit determination to file an appeal. After the end of this period, disposition of the claim shall be considered final.

Requests for appeals should be sent to:

BlueChoice HealthPlan of South Carolina, Inc.
Appeals Department
Mail Code AX-325
PO Box 6170
Columbia, SC 29260-6170

The appeal must state that you are requesting a formal appeal and include all pertinent information regarding the claim in question that you wish to be considered in the appeal. Requests to cover services and supplies that are specifically excluded in the Contract will be treated as appeals; however, because they do not involve medical judgment, such requests aren't eligible for external review.

The following guidelines apply for each type of claim (including the appropriate claim with regard to a Concurrent Care decision), unless both parties agree to an extension:

1. Urgent Claim Appeal

You may request an expedited review process for an Urgent Care Claim either orally or in writing, and all necessary information pertaining to the appeal will be transmitted by telephone, facsimile or other expeditious method. We must issue a decision within 72 hours after we receive your appeal.

2. Pre-Service Claim Appeal

We must issue a decision on a pre-service claim within 30 days after receiving the appeal.

3. Post-Service Claim Appeal

We must issue a decision on a post-service claim within 60 calendar days after receiving the appeal.

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. No deference will be afforded to the initial determination. Individuals involved in the decision-making for claims and appeals aren't compensated or rewarded based on the outcome of the appeals.

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

You may write to us and request an explanation of our basis for stating we meet the above standard.

4. Notice of Appeal Determination

You will be sent a notice if your claim on appeal is approved. If your claim is wholly or partially denied, you will be sent notice of an adverse benefit determination that will:

- state the specific reason(s) for the adverse benefit determination;
- reference the specific plan provisions on which the determination is based;
- describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary;
- describe the plan's claims review procedures and the time limits applicable to such procedures, including information regarding how to initiate an appeal, and a statement of your right to bring a

civil action under section 502(a) of ERISA following an adverse benefit determination on review, if you are enrolled in an ERISA plan;

- disclose any internal rule, guideline, or protocol relied upon in making the adverse determination (or state that such information is available free of charge upon request);
- if the denial is based on medical necessity, experimental treatment or other similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);
- include sufficient information to identify the claim, including the date of service, health care provider, claimant, and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;
- include the denial code and its corresponding meaning; and
- disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

C. EXTERNAL REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION

Requests to cover services, benefits or supplies which are excluded in the Contract/Certificate are not eligible for external review. You will be notified in writing of your right to request an external review. You should submit a written request for external review within four months of receiving that notice. You 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 the following address and telephone number:

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

Standard External 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 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 based on our determination that the service is 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.

We will respond within five business days of your 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 your records to it or telling you in writing that your 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.

You have five business days from the date you receive our response to submit additional information to the IRO in writing. The IRO must consider this additional information when conducting its review. The IRO will also forward this information to us within one business day of its receipt.

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

If your request is not accepted for external review, the IRO will inform you and us 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, we must process the claim subject to applicable Contract and Certificate exclusions, limitations and other provisions within five business days of our receipt of the notification.

Expedited External Reviews

You can request an expedited external review after receiving a notice of a denied claim only if you meet the requirements stated above for a Standard Review and your Physician certifies you have a Serious Medical Condition, or the claim denial concerns a health care service for which you received Emergency Medical Care, and you have not been discharged. 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 expedited 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, but it remains subject to applicable Contract and Certificate exclusions, limitations and other provisions.

We will pay for the 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.

SECTION 9
GENERAL CONTRACT PROVISIONS

9.01 Conformity with Statutes

Any provision of the Contract which, 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.

9.02 Workers' Compensation Not Affected

The Contract is not in lieu of and does not affect any requirements for coverage for Workers' Compensation Insurance.

9.03 Relationship with Providers

The Employer and Members acknowledge and agree BlueChoice 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.

9.04 Relationship Between Parties

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

9.05 Amendments

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

9.06 Legal Actions

You may not bring a lawsuit to recover benefits under this plan until you have exhausted the administrative process described in this Certificate. No action may be brought at all unless brought no later than six years after the time written proof of loss is required to be furnished.

9.07 Policies and Procedures

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

9.08 Summary of Benefits and Coverage

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

9.09 Payment of Claims

All benefits provided in this Certificate and the Schedule of Benefits will be paid promptly upon receipt of due proof of loss. We will pay benefits as described in this Certificate and Schedule of Benefits 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 will pay benefits directly to the Member, except where otherwise required by law. 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 due after the death of a Member will be paid to the Member's estate.

SECTION 10
COMPLIANCE WITH MEDICAL CHILD SUPPORT ORDER

10.01 Group Health Plan Coverage Pursuant to a Medical Child Support Order

A Medical Child Support Order is a judgment, decree, or order (including an approval of a property settlement) that 1) is made pursuant to state domestic relations law (including a community property law) or certain other state laws relating to medical child support; and 2) provides for child support or health benefit coverage for a child of a participant under a Group Health Plan and relates to benefits under the plan. If the Contract is an integral part of an employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the Contract shall provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order.

10.02 Information to be Included in a Qualified Medical Child Support Order

A Medical Child Support Order becomes a Qualified Medical Child Support Order only if such order clearly specifies all of the following:

1. The name and the last known mailing address (if any) of the participant Employee and the name and mailing address of each Alternate Recipient covered by the order
2. A reasonable description of the type of coverage to be provided by the plan to each such Alternate Recipient, or the manner in which such type of coverage is to be determined
3. The period to which such order applies
4. Each plan to which such order applies.

NOTE: An Alternate Recipient is any child of a participant in a Group Health Plan who is recognized under a medical child support order as having a right to enrollment under the plan with respect to such participant.

Additionally, a Medical Child Support Order becomes a Qualified Medical Child Support Order only if such order does not require a plan to provide any type or form of benefit or any option not otherwise provided under the plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993).

10.03 Procedural Requirements

1. **Establishment of Procedures for Determining Qualified Status of Orders.** The Employer as the plan administrator of the Group Health Plan shall establish reasonable procedures to determine whether a Medical Child Support Order is a Qualified Medical Child Support Order and to administer the provision of benefits under such qualified order.

   Such procedures shall meet all of the qualifications:

   A. Be in writing
   B. Provide for the notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the plan of the Medical Child Support Order

C. Permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order

2. **Timely Notifications and Determinations**. In the case of any Medical Child Support Order received by a Group Health Plan:

A. The Employer as the plan administrator shall promptly notify the Employee and each Alternate Recipient of the receipt of such order and the plan's procedures for determining whether a Medical Child Support Orders is a Qualified Medical Child Support Order
B. Within a reasonable period after receipt of such order, the Employer/plan administrator shall determine whether such order is a Qualified Medical Child Support Order and notify the Employee and each Alternate Recipient of such determination.

3. **Actions Taken by Plan Administrators**. If a plan administrator acts in accordance with these procedural requirements in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, then the plan's obligation to the participant and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act.

10.04 Participation of Alternate Recipients

1. A person who is an Alternate Recipient under any Medical Child Support Order shall be considered a participant under the plan only for purposes of the reporting and disclosure requirements of ERISA.

2. A person who is an Alternate Recipient under a Qualified Medical Child Support Order shall be considered a beneficiary under the plan for purposes of any provision of ERISA.

3. Any payment for benefits made by a Group Health Plan pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

4. If an Employee remains covered under a Group Health Plan but fails to enroll an Alternate Recipient under this plan after receiving notice of the Qualified Medical Child Support Order from the Employer/plan administrator, the Group Health Plan shall enroll the Alternate Recipient and deduct the additional premium from the participant Employee's paycheck.

5. Except for any coverage continuation rights otherwise available under this Contract, coverage for the Alternate Recipient shall end on the earliest of the following dates:

A. the date the Employee's coverage ends
B. the date the Qualified Medical Child Support Order is no longer in effect
C. the date the Employee obtains other comparable health coverage through another insurer or plan to cover the Alternate Recipient
D. the date the Employer eliminates family health coverage for all Employees under all of the Employer's Group Health Plans

SECTION 11
CONTACT US

11.01 Resolution of a Question

Questions or concerns about coverage may be directed to Member Services through the website at:

www.BlueChoiceSC.com

or by calling:

803-786-8476 in Columbia or
800-868-2528 outside the Columbia area.

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

Members may also write to:

BlueChoice HealthPlan of South Carolina, Inc.
Member Services (AX-435)
P.O. Box 6170
Columbia, SC 29260-6170

Please include your ID number, name, address and telephone number in your correspondence.

11.02 Complaints and Grievances

Our goal is for you to be completely satisfied with the benefits and services associated with your coverage. If you are dissatisfied, we want to hear from you. 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 (see above for addresses). 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 to the address above.

SECTION 12
DEFINITIONS

Capitalized terms that are used in this Certificate are defined as follows:

Accidental Injury: An injury directly and independently caused by a specific accidental contact with another body or object such as a car accident or blow by a moving object. All injuries you receive in one accident, including all related conditions and recurrent symptoms of these injuries, will be considered one injury. Accidental Injury doesn't include indirect or direct loss that results in whole or partially from a disease or other illness.

Actively-at-work: To be considered Actively-at-work, the Employee must: 1) have begun work and not be absent from work because 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 an agreed upon location. If the Employee does not meet this requirement, coverage will begin on the first day of the next Contract Month after the Employee has returned to active, full-time work.

Admission: The period of time between a Member's entry as a registered bed-patient in a Hospital, Skilled Nursing Facility, Residential Treatment Facility, Rehabilitation Facility or Long-Term Care Facility and the time the Member leaves or is discharged from the Hospital, Skilled Nursing Facility, Residential Treatment Facility, Rehabilitation Facility or Long-Term Care Facility. The Admission may by on an Inpatient or Outpatient basis as determined by the Provider.

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 Section 3.04.

Alternate Facility: A non-Hospital health care 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 Medical Conditions, Urgent Care Services or prescheduled rehabilitative, laboratory or diagnostic services.

Alternate Recipient: Any child of an Employee who is recognized under a Medical Child Support Order as having a right to enrollment under this Contract with respect to such Employee.

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. An Ambulatory Surgical Center includes any licensed facility described in section 1833(i)(1)(A) of the Social Security Act.

Applied Behavioral Analysis (ABA): Behavioral modification to target cognition, language and social skills for Autism Spectrum Disorder.

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.

Authorize or Authorization: Prior approval from BlueChoice for a Provider to provide certain Covered Services to a Member. Covered Services provided must be in accordance with the authorization in order to receive benefits under this Plan.

Autism Spectrum Disorder: The diagnoses designated as such in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

Benefit Period: The period of time set forth on the Schedule of Benefits. The initial Benefit Period may be more or less than twelve (12) months.

Benefit Period Maximum: The maximum number of days or visits that benefits will be provided for a Covered Service in a Benefit Period, as listed in the Schedule of Benefits or this Certificate.

BlueCard® Program: the national program in which all Blue Cross and Blue Shield licensees participate, including BlueChoice. This national program benefits BlueChoice Members who receive Covered Services outside South Carolina.

Care Coordination: Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.

Care Coordinator: An individual within a provider organization who facilitates Care Coordination for patients.

Care Coordinator Fee: A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.

Coinsurance: A percentage of the Allowed Amount that you pay for certain Covered Services, as indicated in the Schedule of Benefits. This percentage applies to the negotiated rate or lesser charge when we have 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.

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

Contract Effective Date: The date this Contract between the Employer and BlueChoice becomes effective, as indicated in the Schedule of Benefits.

Copayment: The fixed amount, if any and as indicated in the Schedule of Benefits, that is payable by the Member to the Provider for certain Covered Services.

Cost Sharing: The Coinsurance, Copayment, and/or Deductible that applies to a Covered Service.

Covered Service: A health care 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 authorized when required under this Contract.

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.

Custodial Care: Care that we determine is provided primarily to furnish to or assist the patient in the activities of daily living and doesn't require a person with medical training to provide the services. Custodial Care includes but is not limited to activities such as bathing, eating, dressing, toileting, continence, transferring, preparation of special diets and supervision over self-administered medications.

Deductible: The amount you are responsible for paying for certain Covered Services before we begin to pay each Benefit Period, as listed in the Schedule of Benefits. The Deductible may not apply to all Covered Services. Coupons for medical services and/or Prescription Drugs may not be used to satisfy any portion of the Deductible.

Dependent: Your legal spouse and any children through age 25 who are covered under the Contract. A Dependent child can be a natural or adopted child, stepchild, foster child or a child who's under your legal guardianship.

This also includes any child of a divorcing/divorced Employee who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under this health plan. This means we provide coverage for Dependents of an Employee who's a Member of this Group Health Plan even though this Employee is the noncustodial parent when a QMCSO exists.

Designated Transplant Facility: A Hospital, named as such by BlueChoice, which has entered into an agreement with or on behalf of BlueChoice to render Medically Necessary and medically appropriate Covered transplant services. A Designated Transplant Facility may or may not be located within BlueChoice's geographic area.

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.

Eligibility Date: The date when all of the eligibility requirements for coverage are met by an Employee or Dependent.

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, these include:

- A medical screening examination that is within the capability of the Emergency department of a Hospital or independent free-standing Emergency department, including ancillary services routinely available to the Emergency department to evaluate such Emergency Medical Condition
- 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 free-standing emergency department (as required under Social Security Act) To Stabilize the patient.

Employee: Any individual employed by an Employer or member of an association who is eligible for coverage and who is so designated to BlueChoice by the Employer.

Employer: An Employer or association with whom BlueChoice has the 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.

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.

Genetic Information: Information about your genetic tests or the genetic tests of your family members, or any request of or receipt by you or your family members of genetic services. Genetic Information does not include the age or sex of any individual.

Group Health Plan: An employee welfare benefit plan) to the extent that the plan provides medical care to Employees or Dependents directly or through insurance, reimbursement, or otherwise.

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

1. Coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance
2. Coverage issued as a supplement to liability insurance
3. Liability insurance, including general liability insurance and automobile liability insurance
4. Workers' compensation or similar insurance
5. Automobile medical payment insurance
6. Credit-only insurance
7. Coverage for on-site medical clinics
8. Other similar insurance coverage, under which benefits for medical care are secondary or incidental to other insurance benefits
9. If offered separately:
    A. Limited scope dental or vision benefits
    B. Benefits for Long-Term Care, nursing home care, home health care, community-based care or any combination of them
10. If offered as independent, non-coordinated benefits:
    A. Coverage only for a specified disease or illness
    B. hospital indemnity or other fixed indemnity insurance
11. if offered as a separate insurance policy:
    A. Medicare supplemental health insurance
    B. coverage supplemental to the coverage provided under military, TRICARE or CHAMPUS
    C. similar supplemental coverage under a group health plan.

Health Status Related Factor: any of the following factors in relation to the Member:

1. health status;
2. medical condition, including both physical and mental illnesses;
3. claims experience;

4. receipt of health care;
5. medical history;
6. Genetic information;
7. evidence of insurability, including conditions arising out of domestic violence; or
8. 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 (ID card): The card issued by BlueChoice showing the Member's identification number.

In-Network Coverage: Benefits for Covered Services or supplies obtained from Providers who have entered into a written agreement with BlueChoice to provide Covered Services to Members.

Incapacitated Dependent: A child who is: 1) incapable of self-sustaining employment because of a Behavioral Health illness or physical handicap; and 2) mainly dependent upon the Employee or the Employee's spouse for support and maintenance. The child must have developed the handicap before he or she reached age 26.

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.

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.

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 served by BlueChoice and approved by the appropriate regulatory body in the state of South Carolina.

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.

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

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

Medically Necessary or Medical Necessity: Health care services that a Physician, exercising prudent clinical judgment, would provide to 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; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For 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 relevant United States Medical and or Behavioral Health community, Physician or Behavioral Health specialty society recommendations, and/or 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: An enrolled Employee or Covered Dependent.

Membership Application: Any mechanism agreed upon by BlueChoice and the Employer for transmitting the necessary enrollment information from its Employees to BlueChoice.

Member's Effective Date: The date (beginning at 12:01 a.m.) on which the Member is enrolled and eligible for benefits under the terms of this Contract.

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.

Network: The facilities, Providers and suppliers we've contracted with to provide health care services.

Out-of-Network Coverage: Benefits for non-Emergency, self-referred Covered Services or supplies obtained from non-Participating Providers unless otherwise provided herein.

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.

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 Certificate.

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.

Prescription Drug Deductible: The amount you are responsible for paying for Covered Prescription Drug Services before we begin to pay each year, as specified in the Schedule of Benefits. This Deductible is separate from the medical Deductible and does not count toward the medical Deductible. The medical Deductible does not apply toward the Prescription Drug Deductible.

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

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

1. Syringes and related supplies for conditions such as diabetes
2. Specific classes of over-the-counter medications designated as Prescription Medication at the sole 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

Qualified Medical Child Support Order (QMCSO): Any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that 1) is made pursuant to State domestic relations law (including a community property law) or certain other State laws relating to medical child support, 2) provides for child support or health benefit coverage for a child of a participant under a Group Health Plan and relates to benefits under the plan, and is qualified in accordance with Section 11.

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) on full-time duty who is in charge of patient care along, with one or more registered nurses (RNs) or licensed practical nurses (LPNs) on duty 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, that 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.

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

Special Enrollment Periods: enrollment periods during which an Employee who is eligible, but not enrolled, for Coverage under the terms of the Contract, or a dependent of the Employee if the dependent is eligible but not enrolled, for Coverage under such terms, may enroll for Coverage under the terms of the Contract. See Section 6.04, Special Enrollment Periods, for additional details.

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

Stabilized: With respect to an Emergency Medical Condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition of a pregnant woman who is having contractions, that the woman has delivered (including the placenta).

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

Substance 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.

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

Telemedicine: Providing medical care using an interactive two-way telecommunications system (like real-time audio and video) that is compliant with the Health Insurance Portability and Accountability Act's security rules by an eligible Provider who's at a different location than you.

Telemonitoring: Services where a Member transmits, whether by facsimile, email, telephone or any other format, his or her specific health data (e.g., blood pressure, weight, etc.) to a health care Provider. Telemonitoring services are not covered.

Tier: The level(s) of coverage specified on the Prescription Drug List with respect to Prescription Medication. The Prescription Drug List includes drugs on different tiers, each with its own copayment and/or coinsurance levels.

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.

Value-Based Program: an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors
and is reflected in provider payment.

Waiting Period: the period of time that an Employee must wait before the Employee is eligible to be Covered under this Contract.