CHOICE COMPLETE℠
MASTER GROUP CONTRACT

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

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

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

The Employer hereby agrees:

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

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

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

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

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

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

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

SECTION I
ELIGIBILITY FOR COVERAGE

I.01 Eligibility

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

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

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

I.02 Election of Coverage

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

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

SECTION II
NONRENEWAL OR DISCONTINUATION OF THIS CONTRACT

II.01 General Provisions

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

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

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

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

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

4. **Termination of Coverage** –

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

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

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

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

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

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

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

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

II.02 Effective Date of Termination

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

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

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

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

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

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

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

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

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

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

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

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

SECTION III
COMPLIANCE WITH STATUTES

III.01 Corporation as Claim Fiduciary

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

SECTION IV
PREMIUM PROVISIONS

IV.01 Premium Calculation

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

IV.02 Changes in Enrollment

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

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

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

IV.03 Changes in Premium Rates

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

IV.04 Payment of Premiums

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

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

IV.05 Grace Period

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

IV.06 Misstatement of Age

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

SECTION V
STANDARD PROVISIONS

V.01 Incontestability

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

V.02 Entire Contract

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

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

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

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

V.06 Time Payment of Claims
BlueChoice will pay completed claims received via paper within 40 business days and completed electronic claims within 20 business days following the later of 1) date the claim is received or 2) the date on which the insurer receives all of the information needed in the format required for the claim to constitute a "clean" claim as defined in the South Carolina Health Care Financial Recovery and Protection Act.

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

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

SECTION VI
GENERAL PROVISIONS

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

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

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

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

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

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

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

VI.07 Group Replacement Standards

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

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

   Rules

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

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

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

Rules

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

VI.08 Right to Modify

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

VI.09 Plan Administration

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

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

VI.10 Identification Card and Certificate of Coverage

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

VI.11 Gag Clause Compliance Attestation

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

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

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

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

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

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

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

VI.12 Notification

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

VI.13 Physical Examination

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

VI.14 Independent Corporation

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

VI.15 GAG CLAUSE PROHIBITION COMPLIANCE ATTESTATION

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

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

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

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

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

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

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

VI.16 Out-of-Area Services

Overview

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

Liability Calculation Method Per Claim

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

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

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

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

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

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

B. Special Cases: Value-Based Programs

BlueCard Program

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

C. Return of Overpayments

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

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

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

E. Nonparticipating Providers Outside Our Service Area

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

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

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

F. Blue Cross Blue Shield Global®

- **General Information**

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

- **Inpatient Services**

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

- **Outpatient Services**

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

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

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

SECTION VII
DEFINITIONS

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

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

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

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

Employee: Any individual employed by the Employer.

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

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

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

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

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

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

GROUP MEDICAL POINT OF SERVICE INSURANCE CONTRACT

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA

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

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

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

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

Scott Graves
President
BlueCross BlueShield Division

INTRODUCTION

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

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

SECTION 1
ELIGIBILITY AND ELECTION OF COVERAGE

ELIGIBILITY

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

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

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

ELECTION OF COVERAGE

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

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

SECTION 2
NONRENEWAL OR DISCONTINUATION OF THIS CONTRACT

GENERAL PROVISIONS.

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

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

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

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

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

4. **Termination of Coverage –**

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

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

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

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

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

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

EFFECTIVE DATES OF TERMINATION

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

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

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

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

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

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

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

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

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

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

SECTION 3
STANDARD PROVISIONS

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

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

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

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

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

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

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

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

SECTION 4
GENERAL PROVISIONS

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

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

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

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

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

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

SUMMARY OF BENEFITS AND COVERAGE

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

GROUP REPLACEMENT STANDARDS

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

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

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

   Rules

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

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

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

Rules

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

GAG CLAUSE PROHIBITION COMPLIANCE ATTESTATION

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

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

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

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

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

5. The Employer agrees to defend, indemnify, and hold harmless the Corporation, its directors, officers, agents, employees, affiliates, successors, and assigns from and against any and all claims, demands, liabilities, damages, losses, suits, costs (including reasonable legal costs) and judgments arising out of or related in any way to the Corporation's completion and submission of one or more Gag Clause

Prohibition Compliance Attestations on behalf of the Group Health Plan in accordance with this Contract, including but not limited to such submissions made where the Employer has failed to provide any or all requested information to the Corporation.

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

BLUE CROSS® AND BLUE SHIELD® ASSOCIATION

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

Out-of-Area Services

Overview

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

Liability Calculation Method Per Claim

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

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

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

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

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

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

B. Special Cases: Value-Based Programs

BlueCard Program

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

C. Return of Overpayments

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

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

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

E. Nonparticipating Providers Outside Our Service Area

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

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

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

F. Blue Cross Blue Shield Global™

- **General Information**

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

- **Inpatient Services**

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

- **Outpatient Services**

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

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

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

CERTIFICATE OF COVERAGE

Choice Complete℠

Benefits are provided both In-Network and Out-of-Network. Using In-Network Providers 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

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

A person enrolled in Choice Complete is automatically entitled to 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 in the Choice Complete Network. However, Prior Authorization may be required for certain services. Please see Section 2 – 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 the paperwork, so you have no bills or claim forms to submit. BlueChoice underwrites these benefits.

Out-of-Network benefits 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 provide a lower level of coverage, and you are responsible for completing claim forms and submitting itemized bills to receive benefits. **You can also be billed for any amount in excess of the Allowable Charge, 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.

We do not discriminate based on race, color, national origin, disability, age, or sex 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.

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

Need your member ID card? Log in to My Health Toolkit®, where your digital ID card is always available. You can view, print, or share your Member 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 Apple or Google app store. 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 Participating Providers.

Your Rights and Responsibilities
As a Member, you have certain rights. You also have responsibilities. As part of our ongoing efforts to keep you informed, we've listed your rights and responsibilities.

You have the right to:

- Be treated with respect and recognition of your dignity and right to privacy.
- Get the information you need to make thoughtful decisions before choosing a Provider or treatment plan.
- Constructively share your opinion, concerns, or complaints.
- Get information from BlueChoice about services provided or care received.

You have the responsibility to:

- Carefully read all health plan materials provided by BlueChoice after we accept you as a Member.
- Ask questions and make sure you understand the information given to you.
- Present your BlueChoice ID card before you get services or care.
- Inform BlueChoice of any information that affects your coverage, including any other insurance you may have.
- Select a representative to act on your behalf in the event you're unable to represent yourself.
- Pay your Cost Share amounts and your premium.
- Tell us if you move.

Summary of Benefits and Coverage
A Summary of Benefits and Coverage (SBC) summarizes the benefit options of your insurance plan. All insurance companies must provide you with a SBC. You can find your SBC by going to **www.BlueChoiceSC.com and then logging into My Heath Toolkit**. However, it is the Employer's responsibility to distribute the SBCs to Employees (and Dependents who are known to live at a different address).

You may also contact a member service advocate and ask us to send you a copy of the SBC. We can send it to you electronically or mail a paper copy free of charge. Please note: the format and content of a SBC is controlled by federal agencies, and some details may appear inconsistent with information in this Certificate or your Schedule of Benefits. If information is inconsistent, the Contract documents are controlling.

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 Choice Complete and accepting this Certificate, 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 Member or by the Employer on the Member's behalf. The Contract may require that the Member contribute to the required premium. Information regarding the premium and any portion of the premium that the Member must pay can be obtained from 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 of the provisions are interrelated, so reading just one or two sections may give you a misleading impression. 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 mean 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 benefits to be covered. Please see Section 2 for the list of items and services that require prior Authorization.

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

SECTION 1
WHAT IS 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 the paperwork, so you have no bills or claim forms to submit. These benefits are paid based on BlueChoice's In-Network Fee Schedule.

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

Authorization, as described in Section 2, must be obtained on certain services to receive maximum benefits.

Benefits for all services are subject to the provisions of the Contract, Certificate and Schedule of Benefits. 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 (if any) limitations, Copayments, Deductibles, Coinsurance and Maximum Payment amounts specified in this Certificate including the Schedule of Benefits and the exclusions and limitations as stated in this Certificate and in the Master Group Contract.

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 regarding to the Contract.

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.

If any service or item that is not an Essential Health Benefit is provided by a non-Participating Provider, it will not be covered.

The following are Covered Services:

Ambulance Service
Professional ambulance services to a local Hospital in the United States are covered in connection with an acute injury or 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 Out-of-Network Providers will be determined in accordance with the applicable Fee Schedule.

Prior Authorization is required for transportation as an Inpatient from one Hospital to a second Hospital using an air ambulance. All the following requirements must be met:

- The first Hospital does not have needed Hospital or skilled nursing care for the Member's illness or injury, such as burn care, cardiac care, trauma care or 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 for Out-of-Network air ambulance services is described in Section 3.02.

Birth Control
Benefits are provided for oral contraceptives and contraceptive devices. Birth control includes female sterilization.

Blue CareOnDemand℠ Powered By MDLive
We provide you with access to ***Blue CareOnDemand Powered by MDLive***, a telehealth service through which you can seek treatment from U.S. licensed health care professionals 24 hours a day, seven days a week and 365 days a year using the convenience of video consultation. Blue CareOnDemand Powered by MDLive providers can treat many of the most common health issues, such as cold and flu symptoms, allergies, skin irritations, pinkeye, ear infections, bronchitis, sinus infections and other specialties. We encourage Members to use the convenience of Blue CareOnDemand Powered by MDLive for treating unexpected, non-emergency health issues. The best way for members to register and create their patient profile is to log-in to their health insurance account by visiting My HealthToolKit.

Once registered, Members can then log in to the MDLive mobile app or website as needed and consult with doctors through video visits.

Blue CareOnDemand is offered through MDLive, an independent company that provides telehealth hosting and software services on behalf of BlueChoice.

Breastfeeding Support, Supplies and Counseling
Benefits will be provided for breastfeeding support and counseling. Breastfeeding support includes benefits for breast pumps. Members must breast pumps from a Provider we designate. Breast pumps are limited to one per year.

Cleft Lip and Palate
Benefits will be provided for the care and treatment of a cleft lip and palate and any condition or illness that is related to or caused by a cleft lip and palate. Cleft lip and palate is a congenital cleft in the lip, palate or both. Care and treatment will include, but are not limited to:

- Oral and facial Surgery, surgical management, and follow-up care.
- Prosthetic treatment such as an obturator, speech appliances and feeding appliances.
- Orthodontic treatment and management.
- Treatment and management for missing teeth (prosthodontics).
- Ear, nose and throat (otolaryngology) treatment and management.
- Hearing (audiological) assessment, treatment and management including surgically implanted hearing aids.
- Physical therapy assessment and treatment.

If a Member with a cleft lip and palate is also covered by a dental policy, then teeth capping, prosthodontics and orthodontics will be covered by the dental policy to the limit of coverage provided and any excess after that will be provided by this Certificate.

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

- The referring health care professional is a Participating health care Provider and has concluded that the person's participation in such trial would be appropriate.
- The person provides medical and scientific information establishing that the person'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.

Dental Care
Reimbursement up to $50 is provided for one oral examination every six months by or under the direction of a licensed dentist. Reimbursement up to $50 is also provided for one dental cleaning (prophylaxis) every six months by or under the direction of a licensed dentist. This service does not have to be Authorized. You will have to file a request for reimbursement to the Company to receive reimbursement. Other than preventive dental services listed, there is no coverage for other dental services related to the teeth and supporting structures, unless specifically listed in this section of the Certificate. Benefits received for dental care do not apply to your Deductible or Out-of-Pocket Limit. These reimbursements do not apply to your Deductible or your Maximum Out-of-Pocket Limit.

Dental Services To Sound Natural Teeth Related to Accidental Injury
Care is for treatment, Surgery or appliances caused by Accidental Injury, except dental injuries occurring through the natural act of chewing or biting. It is limited to care completed within six months of such accident and while the patient is still covered under this Certificate. Members can choose to go to any licensed dentist In- or Out-of-Network. Benefits are subject to the Deductible and Coinsurance. The first Emergency visit does not require Authorization. Any follow-up visit must be Authorized in advance. The dentist should submit an outline of the plan of treatment for BlueChoice's review before he or she provides any further treatment.

Diabetes Management
Benefits are provided for equipment, supplies, outpatient self-management training and education including nutritional counseling for the treatment of Members with diabetes. A health care professional must follow minimal standards of care for diabetes as adopted and published by the Diabetes Initiative of South Carolina.

Diabetes self-management training and education will be provided on an Outpatient basis when done by a registered or licensed health care professional certified in diabetes education.

Durable Medical Equipment (DME)
Benefits are provided for DME and certain orthotics and supplies. 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.

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.

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

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

1. Emergency Care Benefits — In-Network and Out-of-Network

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

      If you are admitted to a Hospital due to an Emergency Medical Condition, you or someone acting on your behalf, must contact BlueChoice within 24 hours or the next working day, whichever is later at 800-950-5387. If the Admission occurs outside the Local Service Area or at an Out-of-Network Provider, you may be required to transfer to a Hospital within the local service area once your condition has Stabilized to receive benefits. If an Admission occurs within 24 hours after an Emergency visit because of the Emergency Medical Condition, the Emergency Copayment, if any, will be waived and the applicable Copayment for Admission will be assessed.

      To be covered, any follow-up care must be provided by an In-Network Provider.

      Cost Sharing for Emergency Services for an Emergency Medical Condition is described in Section 3.02.

B. 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 include but are not limited to Prescription Drug refills, removal of stitches, requests for a second opinion, screening tests or routine blood work, and follow-up care for chronic conditions such as high blood pressure or diabetes.

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

Employee Assistance Program (EAP Service)
Three visits for life management services and three visits for individual and family counseling are provided under the employee assistance program (EAP) through First Sun EAP. Because First Sun EAP is a separate company from BlueChoice, First Sun EAP is responsible for all services it provides. For services, please call First Sun EAP at 1-800-968-8143. First Sun EAP staff are available 24 hours a day, seven days a week.

Costs associated with these visits do not apply to your Deductible or your Out-of-Pocket Limit.

Genetic Counseling
Benefits are provided for genetic counseling. Routine breast cancer susceptibility gene (BRCA) testing is also covered for women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes. Prior Authorization is required.

Habilitation Services
Benefits include physical, occupational and speech therapy for the purpose of assisting a Member with achieving developmental skills, such as a developmental speech delay, developmental communication disorder, or a developmental coordination disorder. Benefits are provided when a Physician prescribes therapy and it is performed by a licensed, professional physical, occupational or speech therapist. Prior Authorization is required. If Prior Authorization is not obtained, no benefits will be provided. Habilitation Services are limited to 30 visits per Member per Benefit Period.

Home Health Care Services
Benefits are provided to an essentially homebound Member in a personal residence. Home health care must be provided by, or through a community home health agency on a part-time visiting basis and according to a Physician-prescribed course of treatment. We must Authorize the care, in advance, based on established home health care treatment before you are eligible. Home health care services are limited to 60 visits per Member per Benefit Period. Home health care includes:

- Services by a registered nurse (RN) or licensed practical nurse (LPN).
- Services provided by a home health aide or medical social worker.
- Nutritional guidance.
- Diagnostic services.
- Administration of Prescription Drugs.
- Medical and surgical supplies.
- Oxygen and its use.
- DME. A separate Authorization is not needed when we approve the entire home health care plan.

Hospice Services
Benefits are provided for hospice services. We must Authorize hospice services before you are eligible for this care. The services must be provided according to a Physician prescribed treatment plan. Hospice services are limited to six months per Member per episode. Hospice services include:

- Services provided by a RN or LPN.
- Physical, speech and occupational therapy. Benefit Period Maximum applies.
- Services provided by a home health aide or medical social worker.
- Nutritional guidance.
- Diagnostic services.
- Administration of Prescription Drugs.
- Medical and surgical supplies.
- Oxygen and its use.
- DME. A separate Authorization is not needed when we approve the entire hospice service plan.
- Family counseling concerning the patient's terminal condition.

Inpatient Facility Services
Benefits are provided for a comprehensive range of benefits when a Member is admitted into 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, Residential 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 60 days per Benefit Period unless otherwise specified in the Schedule of Benefits.

Immunizations
Benefits will be provided for immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), the United States Preventive Services Task Force (USPSTF), and Health Resources and Services and Administration (HRSA). The recommendations may include age and/or frequency restrictions. Immunizations do not include those recommended prior to travel outside of the United States. The ACIP, CDC, USPSTF and HRSA are independent organizations that offers health information and recommendations; they are not affiliated with BlueChoice.

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 will also be provided. We will reduce benefits for Inpatient diagnostic services to the level of benefits for Outpatient services when services could have been safely done on an Outpatient basis.

Mastectomy and Reconstruction
Benefits include hospitalization for at least 48 hours following a mastectomy. If you are released early, then we will provide benefits for at least one home care visit if the attending Physician orders it.

We will also provide benefits for Prosthetic Devices, reconstruction of the breast on which the mastectomy was performed and physical complications for all stages of mastectomy including lymphedemas. This includes Surgery and reconstruction of the nondiseased breast to produce a symmetrical appearance as determined in consultation with the attending Physician and the patient.

Maternity Care
Benefits will be provided for prenatal and postnatal care, including the hospitalization and related professional services for at least 48 hours after a vaginal delivery (96 hours following a cesarean section) or the date of discharge from the Hospital, whichever occurs first. The day of delivery or Surgery is not counted in the 48 or 96 hours. 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 within 31 days of birth and applicable premium must be paid for benefits to be paid.

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.

Medical Supplies
Benefits will be provided for items you need for treatment of an illness or injury and must be dispensed by or under the direction of a Physician. Supplies include syringes and related supplies for conditions such as diabetes, dressings for cancer or burns, catheters, external opening (ostomy) bags, test tapes, kidney (renal) dialysis supplies, and surgical trays.

My Health Novel®
If you wish to make healthy lifestyle changes to manage your weight and reach your health goals, log into My Health Toolkit to complete an assessment to determine if you are eligible to participate in a 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). My Health Novel is a virtual network of resources with "chapters" designed to address four health concerns that can be challenging

Out-of-Country
We will provide out-of-country benefits based on the in-Network Provider allowance or the total charge, whichever is less. Out-of-country benefits consist of all Covered Services provided or supplies received outside the United States. However, services must be provided through Blue Cross Blue Shield Global Core®. Please note that these Global Core Providers may bill you the difference between the allowance and the total charge. To find a BlueCard Provider outside of the United States, visit the BlueCard Doctor and Hospital Finder website (www.BCBS.com), call the Blue Cross Blue Shield Global Core service center at 800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. You can also visit www.bcbsglobalcore.com.

Pain Management Program
We may, according to our medical guidelines, approve services for a multi-disciplinary pain management program that includes Physicians of different specialties and non-Physician Providers who (1) specialize in the assessment and management of patients with a range of painful diagnoses and chronic pain and (2) provide the interventions needed to allow the patients to develop pain coping skills and discontinue analgesic medication. Services, supplies or charges for a multi-disciplinary pain management program must be Authorized in advance. Authorization approval shall be on a case-by-case basis, in our discretion, and contingent upon such program satisfying our medical policies. The Member is solely responsible for seeking Authorization in advance, regardless of the location of the Provider offering the multi-disciplinary pain management program.

Physician Services (Primary Care Physician and Specialist)
Benefits are provided for the following:

- Office/Outpatient Services — These include care and consultation by a Physician or other clinician in an Outpatient setting for the examination, diagnosis or treatment of an injury, illness or Behavioral Health service.

- Inpatient Services — These include care and consultation provided in an Inpatient setting for the examination, diagnosis or treatment of an injury or illness, including Behavioral Health services.
  - Inpatient and Intensive Care Visits — Visits are limited to one per day. Inpatient medical services also include diagnostic services and therapy services done concurrently with medical or Behavioral Health care.
  - Consultation — If a consultation with another Physician is ordered by a patient's attending Physician, benefits are provided for one consultation per consulting Physician.

  We will not provide benefits for daily medical visits by more than one Physician unless and to the extent that the Member has one or more separate medical or Behavioral condition the attending Physician cannot treat. In this type of situation, benefits may be provided for one daily visit by each Physician.

- Surgery — Benefits include preoperative and postoperative care as well as daily care by the Physician who performed the Surgery if you are an Inpatient.

  Benefits are provided for medical visits by another Physician if and to the extent that you have a condition the Physician who performed the Surgery cannot treat.

  - Multiple Surgical Procedures — When multiple surgical procedures are performed through the same incision or body opening during one operation, benefits are provided only for the primary procedure unless more than one body system is involved, or the procedures are required for management of multiple traumas.

    If two or more surgical procedures are performed through different incisions or body openings during one operation, benefits are provided for the additional procedures at 50 percent of the Allowable Charge for each procedure.

    If a procedure that could have been performed in one step or stage is instead performed in two or more steps or stages, the total benefits payable will be limited to the Allowed Amount as if the procedure had been performed in one step or stage.

If two or more Physicians, other than an assistant at Surgery or an anesthesiologist, perform procedures in conjunction with one another, we will prorate the Allowed Amount between them when so required by the Physician in charge of the case. This benefit is subject to the above paragraphs.

When more than one skin lesion is removed at one time, we provide full benefits for the largest lesion, 50 percent of the Allowed Amount for the removal of the second largest lesion and 25 percent of the Allowed Amount for removal of any other lesions.

We designate certain surgical procedures that are normally exploratory in nature as "independent procedures." The Allowable Charge is covered when such a procedure is performed as a separate and single procedure. However, when an independent procedure is performed as an integral part of another surgical service, only the Allowable Charge for the other surgical services (and not the Independent Procedure will be covered.

- Surgical Assistant — Services of a Physician who actively assists the operating Physician during an eligible Surgery in a Hospital are only available if all the following conditions are met:
  - The complexity of the procedure or the patient's condition warrants an assistant surgeon.
  - An intern, resident or house Physician is not available to assist.
  - Non-Physicians (e.g., Physician's assistants, first assistants, certified surgical assistants and nurse practitioners) are considered ancillary support for the surgeon and will not be considered an assistant at Surgery, unless the non-Physician is credentialed for the procedure at the Hospital where it is performed.
- Anesthesia — Benefits are available for services provided by a Physician or a certified registered nurse anesthetist, other than the attending surgeon or his or her assistant.

- Chemotherapy — Benefits include the treatment of malignant disease by chemical or biological antineoplastic agents that have received full, unrestricted market approval from the U.S. Food and Drug Administration (FDA). The FDA is an independent organization that provides health information you may find helpful.

- Dialysis Treatment — Benefits include the treatment of acute renal failure or chronic irreversible renal insufficiency to include hemodialysis or peritoneal dialysis. Dialysis treatment includes home dialysis. Dialysis treatment is only covered when provided by an In-Network Provider and requires Authorization.

- Radiation Therapy — Benefits include the treatment of disease by X-ray, radium or radioactive isotopes.

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

Prescription Drugs
Benefits are provided for the Prescription Drugs listed in the Prescription Drug List (PDL). BlueChoice works with a team of health care Providers to choose drugs that provide quality treatment. We cover drugs on the PDL if:

- The drug is Medically Necessary.
- It is filled at a Network pharmacy.
- Other requirements are followed, including but not limited to: Prior Authorization, Quantity Limits and Step Therapy.

The PDL has seven coverage levels called Tiers. The Schedule of Benefits shows how much you pay for a drug on each of the Tiers.

Benefits are limited to 31-day or a 90-day supply when purchased at retail pharmacy and a 90-day supply when purchased through the mail-order pharmacy. A 90-day supply is **not available** for specialty drugs.

More information about the PDL and Network pharmacies can be found on our website at www.BlueChoiceSC.com/ChoiceCompleteFormulary. Here is an explanation of the Tiers:

- Tier 0 – These drugs are considered preventive medications under the Affordable Care Act, and we cover them at no cost to you.
- Tier 1 – Drugs on this Tier are usually generic drugs. They will typically cost the least amount of money out of your pocket (other than Tier 0).
- Tier 2 – Drugs on this Tier are usually preferred brand-name drugs. They typically cost less than other brand-name drugs.
- Tier 3 – Drugs on this Tier are usually non-preferred brand-name drugs. They typically cost more than other brand-name drugs and may have generic equivalents.
- Tier 4 – Drugs on this Tier are usually generic specialty drugs that are used to treat complex conditions. They are typically expensive but less expensive than Tier 5 drugs.
- Tier 5 – Drugs on this Tier are usually preferred specialty drugs that are used to treat complex conditions. They are typically expensive.
- Tier 6 – Drugs on this Tier are usually specialty drugs that are used to treat complex medical conditions. They are typically the most expensive drugs available.

No Tier is restricted to a specific class of Prescription Drugs. Any Tier may contain a mix of generic, brand-name or non-brand name drugs or specialty medications, including infusible or injectable drugs.

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.

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.

If a Participating Physician prescribes a nongeneric drug, there is a less-expensive equivalent generic or covered over-the-counter drug available, and the Member still requests the nongeneric drug, then any difference between the cost of the covered generic or covered over-the-counter drug and the higher cost of the nongeneric drug will be the responsibility of the Member. This will be in addition to any Copayment or Coinsurance appropriate to the nongeneric drug you are buying. 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 you be charged more than the actual retail price of the drug.

Until your Out-of-Pocket Limit is met, you will pay one or more of the following for each Prescription Drug, depending on the plan selected: Prescription Drug Deductible, Copayment, Deductible and/or Coinsurance. Once you have met your Out-of-Pocket Limit, you will no longer have to pay out of pocket for covered benefits until a new Benefit Period begins.

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 needs 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 it was approved for by the 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, usually a month. This is to make sure you are using the drug safely and based on FDA guidelines. If we determine a Member has used multiple doctors or pharmacies to get more of a Prescription Drug than 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 second-choice drugs if you have already tried a 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.

We contract with a pharmacy benefit manager (PBM) 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. Optum Rx® is an independent company that offers a pharmacy network on behalf of BlueChoice.

BlueChoice receives financial credits directly from drug manufacturers and through the PBM. The credits are used to help stabilize overall rates and to offset expenses. Reimbursements to pharmacies, or discounted prices charged at pharmacies, are not affected by these credits. Any Coinsurance percentage a Member must pay for Prescription Medications is based on the negotiated rate or lesser charge at the pharmacy. It 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.

Formulary Exception Request (Standard or Expedited)
If a Prescription Drug is not covered, it may be helpful to discuss other covered alternatives with your Physician. If not medically viable, you may request a formulary exception. An exception request may be made by the Member, the Member's designee or the Member's prescribing Provider (or other prescriber as appropriate). To request and gain access to clinically appropriate drugs not otherwise covered by the health plan, you may contact our PBM. Our PBM will work with the prescribing Physician to get any medical records or other necessary information to process the request. We must act on a standard request within 72 hours and on an expedited request within 24 hours after we receive your request for a formulary exception. Expedited requests are available only when you have exigent circumstances. These include a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a non-formulary drug. For a standard formulary exception, we will notify you no later than 72 hours following receipt of the request. If approved, we will provide coverage of the approved nonformulary drug for the duration of the prescription, including refills. For an expedited formulary exception, the determination will be made no later than 24 hours following receipt of the request. If approved, we will provide coverage of the non-formulary drug only for the duration of the exigent circumstances.

If your formulary exception request is denied, you can ask for an exception review. Either you, your prescribing Provider or a person you designate can make the request. You can ask for an exception review by contacting us to begin the process at:

OptumRx
Prior Authorization Department
P.O. Box 25183
Santa Ana, CA 92799
Fax: 844-403-1029

The external exception review will be assigned to an independent review organization will decide on your exception review. We will notify you or your designee, along with the prescribing Provider, of the coverage determination. If the original request was a standard formulary exception request, we will notify you no later than 72 hours following receipt of the request and, if approved, will provide coverage of the approved non-formulary drug for the duration of the prescription. If the original formulary exception request was an expedited request, the determination will be made no later than 24 hours following receipt of the request and, if approved, will provide coverage of the non-formulary drug only for the duration of the exigency.

Preventive Screenings
A limited number of services are provided as preventive care with no Cost Sharing. Benefits will be provided as follows:

- The USPSTF recommended Grade A or B services
- Services recommended for children and women by HRSA
- Preventive prostate screenings and lab work according to American Cancer Society (ACS) guidelines
- Pediatric oral and vision care as recommended by the USPSTF Grade A or B services and HRSA
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the ACIP of the CDC
- 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 USP STF or (2) an immunization that has in effect a recommendation from the ACIP of the CDC regardless of whether the immunization is recommended for routine use

Virtual colonoscopies may be covered but are subject to medical management guidelines and are subject to Authorization. Multitargeted stool DNA testing (FIT-DNA) must meet BlueChoice's medical guidelines and/or policies to be covered.

These services are covered In-Network only. Preventive care must meet the age and/or condition guidelines and 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.

Prosthetics
Benefits are provided for a prosthetic, other than a dental or cranial prosthetic, that meets minimum specifications for the body part it is replacing regardless of the functional activity level. If more than one Prosthetic Device can meet your functional needs, benefits are available only for the Prosthetic Device that meets the minimum specifications for your needs. If you purchase a Prosthetic Device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost. The item must be a standard, non-luxury item as determined by us. A penile prosthesis will be considered for benefit only after prostate Surgery. Replacement of Prosthetic Devices due to damage or wear and tear are not covered.

Rehabilitation Services
These include:

- **Cardiac Rehabilitation**
  Benefits are provided for Phase 1 and 2 cardiac rehabilitation when provided within 30 days following a cardiac event.

- **Physical, Occupational and Speech Therapy**
  Benefits are provided when a Physician prescribes therapy and it is performed by a licensed, professional physical, occupational or speech therapist. Physical, occupational and speech therapy services are limited to 30 visits per Member per Benefit Period for all services combined.

- **Pulmonary Rehabilitation**
  Benefits are provided when pulmonary rehabilitation is in conjunction with a covered lung transplant.

Authorization is required for Inpatient rehabilitation.

Telehealth
Benefits will be provided for telehealth services that are initiated by either a Member or Provider and are offered by Network Providers who have been credentialed as eligible telehealth Providers.

Telemedicine
Benefits will be provided for Telemedicine and provided through a Provider we designate. Services include but are not limited to consultation, diagnosis and treatment where the services would otherwise be covered if you were in person. Telemedicine visits are considered office visits and will count toward any limits for office visits.

Telemedicine services will be covered when the services performed are Covered Services under the Contract and Certificate and under both of the following circumstances:

1. The medical care is individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not more than the Member's need.
2. The medical care can be safely furnished, and there is no equally effective, more conservative and less costly treatment available.

The following are examples of services that are not Telemedicine services and will not be covered:

1. Telephone conversations
2. Email messages
3. Facsimile transmissions
4. Internet-based audio-video communication that is not secure and HIPAA-compliant (e.g., Skype).

Transplants (Human Organ and/or Tissue)

We provide benefits for covered transplants only when you get Authorization, and the services are provided at Blue Distinction® Centers for Transplants.

Organ transplant coverage includes all expenses for medical and surgical services a Member receives for human organ and/or tissue transplants 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. 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 nonmalignant diseases of bone marrow.

   Benefits for allogeneic or syngeneic bone marrow transplants are described in items 3 and 4 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

Urgent Care Services
Urgent Care services are Covered Services when provided at an Alternate Facility such as an Urgent Care center or after-hours facility.

Varicose Vein
Benefits will be provided for the treatment of varicose veins when the services are received from In-Network Providers. In-Network Providers must be centers or offices accredited by the Intersocietal Accreditation Commission. Covered Services will be limited to $5,000 per Member per lifetime. Authorization is required. If Authorization is not obtained, no benefits will be provided.

Vision Care for Adults (ages 19 years and older)
Benefits are provided for exams and purchase of materials as noted on the Schedule of Benefits when services are received from a EyeMed Provider.

Please consult your EyeMed Provider for information on discounts for which you may be eligible. Adult routine vision care is provided under an agreement between EyeMed and BlueChoice. EyeMed is an independent company that provides adult vision services on behalf of BlueChoice.

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. **Benefits received for vision care services do not apply to your Deductible or Out-of-Pocket Limit.**

Vision Care for Children (Pediatric Vision Care)
Pediatric vision services are covered for children through age 18. Benefits are provided for exams and purchase of materials as noted on the Schedule of Benefits when services are received from a EyeMed Provider.

Please consult your EyeMed Provider for information on discounts for which you may be eligible.

Pediatric vision care is provided under an agreement between EyeMed and BlueChoice.

OUT-OF-AREA SERVICES

Overview

BlueChoice has 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") don't 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.

B. 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 your Group Health Plan 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.

C. 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.

D. Nonparticipating Providers Outside Our Service Area

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

E. Blue Cross Blue Shield Global®

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 the Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists 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 Blue Cross Blue Shield Global Core Service Center for assistance, Hospitals will not require you to pay for covered Inpatient services, except for your cost-share amounts.

  In such cases, the Hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact BlueChoice to obtain Authorization for non-Emergency Inpatient services**.

- **Outpatient Services**

  Physicians, urgent care centers and other Outpatient Providers located outside the BlueCard service area will typically require 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 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 BlueChoice, 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.

SECTION 2
PROCEDURES FOR OBTAINING BENEFITS

With Choice Complete, you have benefits for Covered Services provided by any licensed health care professional. For coverage at the In-Network benefit level, services must be received from a Provider in the BlueChoice Network – a Participating Provider. Or you may see a health care professional who is not in the BlueChoice Network and 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 Sections 1 and 2 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 http://www.BlueChoiceSC.com/ChoiceCompleteFindcare or by calling 803-786-8476 in Columbia or 800-868-2528 when outside the Columbia area.

Enrolling for coverage under Choice Complete 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 a separate company that assists in management of Behavioral Health services and substance abuse benefits, including prior Authorization, and the Behavioral Health Provider network 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 ends, is modified, 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, and you are a Continuing Care Patient of the Provider at the time, you may be able to receive Network benefits for that Provider's services for a limited time. We will attempt to notify you if and when these situations arise with your Providers and explain your right to elect continued Network coverage, but such continued Network coverage is not automatic. Please contact us or have your Provider contact us to get the continued Network coverage.

We recommend you use a form for this request. The form is on our website at www.BlueChoiceSC.com or you can call the Member Services phone number on your BlueChoice ID card. Your treating Physician should include a statement that confirms 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 requirements for continuation of care. If we need more information, we may contact you or the Provider.

If you qualify for continued In-Network status, we will provide In-Network benefits for you, for those services from that Provider for the course of treatment relating to your status as a Continuing Care Patient, for 90 days or until the date you are no longer a Continuing Care Patient with respect to Provider, whichever comes first. 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. They are subject to the provisions, limitations and exclusions of this Contract. It is your responsibility to get this required Authorization before you get services.

2.04 Prior Authorization

The following items require prior Authorization 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 Medications for Behavioral Health disorders
- Dental services to Sound Natural Teeth Related to Accidental Injury after initial visit
- Genetic counseling
- Habilitation services
- Home health services
- Hospice services
- Covered transplants, which must be obtained at Blue Distinction® Centers for Transplants
- Durable Medical Equipment (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
- Procedures and/or 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 the continued treatment is not approved, we may deny benefits for the continued portion of the treatment or stay. Network Providers in South Carolina are responsible for providing information relating to the concurrent reviews. In addition, if continued benefits are denied, Network Providers in South Carolina can't bill you for the continued treatment or stay.

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 determination is made by BlueChoice in accordance with all 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're 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/ChoiceCompleteFindcare or call BlueCard Access at 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 Choice Complete Provider, 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 (nonCovered Services, Deductible, Copayment and Coinsurance)
- BlueChoice will send you a complete 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:

- File all claims for Covered Services directly to BlueChoice,
- 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,
- Accept the Fee Schedule (minus any applicable Coinsurance, Copayment or Deductible) as payment in full for Covered Services, and
- Obtain the necessary Authorizations.

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

3.02 Special Out-of-Network Rules

If you get treatment from an Out-of-network Provider as described, we may cover your treatment 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 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 relating to Emergency Services furnished at an emergency department visit. In Emergency situations, no prior Authorization is required. For post-Stabilization services, the Provider or facility may furnish you with a notice of treatment by a non-Network Provider and an opportunity to consent to the treatment in advance, in which case this Section 3.02 will not apply, and the post-Stabilization services will not be covered by this Certificate, except for services furnished due to unforeseen, urgent medical needs.
- You seek non-Emergency treatment at an In-Network Hospital, Hospital outpatient department, Critical Access Hospital, or Ambulatory Surgical Center, but during your treatment, you receive services from a non-Network Provider. An example of this would be if you have Surgery performed in a Network Hospital; your surgeon is In-Network, but the anesthesiologist is out-of-Network. Except for certain ancillary services, when this occurs, the Provider may furnish you a notice of treatment by a non-Network Provider and an opportunity to consent to the treatment in advance, in which case this Section 3.02 will not apply and those services will not be covered by this Certificate.
- 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 these things has occurred, please contact us using the information on the back of your ID card or as shown in the section 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. Notwithstanding any provision of the Contract to the contrary, if the Contract generally provides benefits for any type of injury, then in no event shall an exclusion or limitation of benefits be applied to deny coverage for such injury if the injury results from an act of domestic violence or a medical condition, including both physical and Behavioral Health condition, even if the medical condition is not diagnosed before the injury.

Benefits are not provided for:

1. Services and supplies that aren't Medically Necessary, not needed for the diagnosis or treatment of an illness or injury, or not specifically listed in What Is Covered.

2. Any Covered Service provided more than an applicable limit described in this Certificate or the Schedule of Benefits.

3. Services and supplies you received before you had coverage under this Group Contract or after you no longer have this coverage except as described in the Extended Benefits for Total Disability section of this Certificate.

4. Services, supplies or Prescription Drugs for which you're entitled to benefits under Medicare or any other governmental program, except for Medicaid, or for which you're not legally responsible for paying.

5. Benefits for injuries or conditions paid by workers' compensation or settlement of a workers' compensation claim.

6. Any charges by the Department of Veterans Affairs (VA) for a service-related disability or care in any state or federal Hospital for which you aren't legally responsible.

7. 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.

8. All Admissions to Hospitals or free-standing rehabilitation Facilities for physical rehabilitation when the services are not done at a designated Provider and/or you don't get the required Authorization.

9. Treatment resulting from war or acts of war, whether declared or undeclared; while participating in a riot or uprising; or while in the military service or its auxiliary units.

10. Any illness or injury received directly or indirectly, related to and/or contributed to, in whole or in part, while committing or attempting to commit a felony or while engaging or attempting to engage in an illegal act or occupation.

11. Any service (other than Substance Use Disorder Services), Medical Supplies, charges or losses directly or indirectly resulting, from, related to and/or contributed to, in whole or in part, a Member being Legally Intoxicated or under the influence of alcohol, chemicals narcotics, drugs and/or other substances, 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, chemical, narcotic, drug and/or substance levels upon request by us. If a Member refuses to provide these test results, no benefits will be provided.

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

13. 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
    - 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)

14. The following transplants are not Covered Services:

    a. 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
    b. Adrenal tissue to brain transplants
    c. Procedures that involve the transplantation of fetal tissues into a living recipient
    d. Mechanical or animal organ transplants

15. Services and supplies related to transplants involving mechanical or animal organs, human organ and/or tissue transplant procedures when you do not get the required Authorization or where the services are not performed at Blue Distinction Centers for Transplants, or unless specifically listed in this Certificate, the Schedule of Benefits, or applicable law.

16. Services and supplies related to cosmetic Surgery, as determined by us, unless otherwise required to be covered by the 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 because of an injury. Excluded cosmetic Surgery includes but isn't 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.

17. Reduction mammoplasty for macromastia unless the Member's BMI is less than or equal to 30 and meets Medical Necessity in accordance with BlueChoice's medical guidelines.

18. Any treatment or Surgery for obesity (even if morbid obesity is present), weight reduction or weight control, such as but not limited to gastric bypass, insertion of stomach (gastric) banding, intestinal bypass, wiring mouth shut, liposuction or complications from it, unless and to the extent such services may be covered under, and you receive such services while participating in, an approved program listed under the Covered Services section of this Certificate. 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.

19. Except to the extent covered as vison care for children (Pediatric Vision Care) as stated in this Certificate, the Schedule of Benefits, or as required by law, eyeglasses, contact lenses (except after cataract Surgery and as shown in the children's Vision Coverage sections), hearing aids and exams for the prescription or fitting of them. Any Hospital or Physician charges related to refractive care, such as radial keratotomy (Surgery to correct nearsightedness), keratomileusis (laser eye Surgery or Lasik), lamellar keratoplasty (corneal grafting) or any such procedures that are designed to alter the refractive properties of the cornea.

20. Home health care and hospice services, except to the extent provided in the What Is Covered section.

21. Any medical social services, visual therapy, or private-duty nursing services, except when an Authorized home health care plan or hospice services program.

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

23. Biofeedback, unless Authorized.

24. Services or supplies related to an abortion, except:
    - For an abortion performed when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused or arising from the pregnancy
    - When the pregnancy is the result of rape or incest

25. Any services, supplies or drugs for the diagnosis or treatment of infertility. This includes but isn't limited to fertility drugs, lab and X-ray tests; reversals of tubal ligations or vasectomies; surrogate parenting; artificial insemination; and in vitro fertilization.

26. Services and supplies for the diagnosis or treatment of sexual dysfunction due to any medical condition or organic disease. This includes but is not limited to drugs, lab and X-rays, tests, counseling, procedures to correct sexual dysfunction, or penile prosthesis, except after Medically Necessary prostate surgery.

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

28. 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.

29. Any behavioral, educational, or alternative therapy techniques to target cognition, behavior, language and social skills modification, including:
    a. Applied behavioral analysis therapy
    b. Teaching, expanding, appreciating, collaborating and holistic (TEACCH) programs
    c. Higashi schools/daily life
    d. Facilitated communication
    e. Floor time
    f. Developmental Individual-Difference Relationship-Based Model (DIR)
    g. Relationship development intervention (RDI)
    h. Holding therapy
    i. Movement therapies
    j. Primal therapy
    k. Group socialization
    l. Art therapy
    m. Music therapy
    n. Animal-assisted therapy

30. 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.

31. Any services, supplies or treatment for excessive sweating.

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

33. 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.

34. Adjustable cranial orthosis (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling Surgery.

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

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

37. Preconception testing or preconception genetic testing.

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

39. An assistant at Surgery when not Medically Necessary or when the assistant at Surgery does not have surgical privileges at the facility or Hospital.

40. 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, the Schedule of Benefits.

41. Telemonitoring, telehealth and telemedicine except as provided herein or shown in the Schedule of Benefits or Covered Services.

42. 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).

43. Physician services directly related to the care, filling, removal, or replacement of teeth; the removal of impacted teeth; and the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. This includes but isn't limited to apicoectomy (dental root resection), root canal treatment, alveolectomy (Surgery for fitting dentures) and treatment of gum disease. Exception is made, for dental care to Sound Natural Teeth for up to six months after an accident and for cleft lip and palate services, except to the extent provided in this Certificate and the Schedule of Benefits.

44. Luxury or convenience items, whether a Physician recommends or prescribes them.

45. 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 Covered Services section.

46. 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 subacute place of care such as a Skilled Nursing Facility.

47. 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.

48. Services, supplies and equipment that have nontherapeutic uses or that are available over the counter, such as but not limited to air conditioners, whirlpool baths, spas, humidifiers or dehumidifiers, wigs, fitness supplies, vacuum cleaners, or air filters, and common first aid supplies, even with a prescription.

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

50. The following Prescription Medications and/or specialty drugs:
    a. That are used for or related to nonCovered 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. We also exclude all vitamins, except for prenatal vitamins due to pregnancy or otherwise covered as preventive care and purchased at a Participating pharmacy.
    b. That are used for infertility.
    c. That are more than the number of days' supply allowed as shown in the Covered Services section.
    d. That are for refills more than the number specified on your Physician's prescription order.
    e. That are for more than the recommended daily dosage defined by BlueChoice unless Authorization is sought and received.
    f. When administered or dispensed in a Physician's office, Skilled Nursing Facility, Residential Treatment Facility, Hospital, or any other place that is not licensed to dispense Prescription Medications.
    g. That are available over the counter or when there's an over-the-counter drug equivalent that contain the same active ingredients as the prescription version, including any over-the-counter supplies, devices, or supplements.
    h. 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.
    i. That are medications classified as self-administered drugs when obtained, purchased and/or administered at a doctor's office or in an Outpatient setting.
    j. That require Authorization and the Authorization is not received.
    k. That requires step therapy when a step therapy program is not followed.
    l. That are received Out-of-Network, unless due to an Emergency Medical Condition that is treated at an Urgent Care Center or Hospital Emergency Room or free-standing Emergency Room.
    m. That are not on the Prescription Drug List.
    n. That are medications or drugs for which some or all 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.

o. 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.
p. That are Prescription Drugs and pharmaceuticals that could be covered under both the medical and Prescription Drug portion of this coverage. In that case, coverage is provided under the Prescription Drug benefit only.

51. 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.

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

53. Any services or supplies a member of your family provides, including the dispensing of drugs. A member of your family means spouse, parents, grandparents, brothers, sisters, aunts, uncles, child or in-laws.

54. Any service, supply or treatment for complications resulting from any non-covered procedure, condition or drug.

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

56. Any of the following services associated with a clinical trial:
- Services that are not considered routine patient care costs and 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 and 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 Waiting Period will never exceed 90 days. 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 subsection 1 above. 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.

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

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 and is 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 under terms of 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 the Waiting Period, unless the Waiting Period is 90 days or more. In no event will coverage begin later than 90 days after first becoming eligible. 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; 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.
    b. For adopted children other than a newborn, coverage shall begin upon temporary custody and will continue if 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(s) eligible for coverage but not yet enrolled may enroll or change from one Health Plan to another if each person seeking enrollment meets one of the requirements listed below:

1. The person had coverage 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:
    1. Was under a COBRA continuation coverage provision and the coverage has exhausted; or
    2. Was not under such a provision and either the coverage was terminated because of loss of eligibility for the coverage, including because 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. In connection with a Dependent, a court has ordered that coverage be provided for the Dependent and a request for enrollment is made within 30 days after the issuance of the court order.

3. You or a Dependent loses Minimum Essential Coverage. This doesn't include loss due to failure to pay premiums on a timely basis (including COBRA premiums) or rescission of coverage.

4. You gain a Dependent or become a Dependent through marriage, birth, adoption, or placement for adoption.

Marriage
If you marry, the Effective Date of coverage pursuant to the Special Enrollment Period is the first day of the next month after we receive notice of the special enrollment. If you're eligible under this plan, but aren't enrolled and you marry, then you're also eligible to enroll in the plan. You must request coverage within 31 days of the marriage.

Loss of Minimum Essential Coverage
If you or a Dependent loses Minimum Essential Coverage, the Effective Date of coverage pursuant to the Special Enrollment Period is the first day of the next month after we receive notice of the special enrollment. If you're eligible under this plan but aren't enrolled, you're also eligible for this special enrollment. In this situation, you must request coverage within 31 days of the qualifying event.

Birth, Adoption or Placement for Adoption
If you or your spouse gives birth, adopts a child or a child is placed with you or your spouse for the purpose of adoption while this policy is in force, then the child may be enrolled. If you're eligible under this plan but aren't enrolled and you or your spouse has a child, adopts a child or is in the process of adopting a child, you and your spouse can enroll in this plan if you meet the applicable eligibility requirements for coverage. In both situations, you must request coverage within 31 days of the child's birth, adoption or placement for adoption and pay any premium that may be due.

For an adopted child, coverage will start when you pay the appropriate premium, if any, as follows:
1. From the moment of birth for a child you or your spouse legally adopts within 31 days of the child's birth
2. From the moment of birth for a child for whom you or your spouse has temporary custody and have begun adoption proceedings within 31 days of the child's birth
3. When the adopted child isn't a newborn, upon the date of adoption or placement for adoption with you or your spouse. Coverage will continue if you or your spouse has custody of the child.

Your Effective Date for special enrollment for triggering events, except birth, adoption, placement for adoption or marriage, is the first day of the next month after we receive notice of the special enrollment.

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

3. Unless a later date is specified in the Contract, the date on which the Member ceases to be eligible as a Subscriber or enrolled Dependent.

In no event will a Member's coverage be terminated because of his or her health status or requirements for health services. However, the Employee must be permanently working an average of 30 hours per week, including paid leave, unless (1) the Employee is on an Employer-approved leave of absence equal to or less than 90 days or (2) the Employee's absence is otherwise protected by applicable law beyond the 90 days noted in subsection 1 above. If the Employee is no longer working an average of 30 hours per week, including paid, or on approved leave of absence equal to or less than 90 days, or beyond 90 days if protected by applicable law, coverage will end. Coverage will also end at the end of the approved leave of absence if the Employee does not return to work.

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 paragraphs in this section 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 3, How To File a Claim, of this Certificate.

6.03 Extended Coverage for Incapacitated Dependent

The coverage of an Incapacitated Dependent under this Contract will not be terminated simply because the Dependent reaches age 26. Coverage may be continued provided proof of such incapacity is furnished to BlueChoice by the Employee within 31 days of the Dependent reaching age 26, or within 31 days of the Employee first enrolling in coverage for a Dependent who is older than age 26 but the incapacitation began before age 26, if coverage remains in force for the Employee. For an Incapacitated Dependent to remain covered, we must receive a Physician's written report at least every two years.

6.04 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 Certificate, 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 small 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 or 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.

6.05 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.

6.06 Continuation Coverage Under State Law

An Employee who leaves the employ of the Employer while the Contract is in force has the right to continue coverage under the group Contract for the fractional Contract Month remaining at termination plus six additional Contract Months. The Employee must pay to the Employer, before each Contract Month, the full group premium for this continuation of coverage, including any portion usually paid by the former Employer. This continuation 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 under this section if the Member is entitled under federal law (COBRA) to continuation of coverage for a period of greater than six months. Continuation of Coverage is subject to this Contract, or a successor contract, 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.

6.07 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 written proof of insurability. The spouse must apply for the policy and send us the required premium within 60 days following the decree of divorce. 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. ensures that 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. This includes medical, dental and Prescription Medications. 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.

Benefits are <u>not</u> coordinated between the two portions of this Open Access product.

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 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 is secondary to Medicare as mandated by federal law and if the person 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 person 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 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 amount again. 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 from 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 based on 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 to determine eligibility for benefits 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

1. Initial Claims

A. Urgent Claims

An urgent claim is any claim for medical care or treatment where deciding 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.

B. 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, 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 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 decide. You have 60 calendar days to send us the required information. If we do not receive the required information within the 60-day period, we may deny the claim.

C. Post-Service Claims

A post-service claim is a claim for services that already have been provided or where 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 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 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.

D. Concurrent Care Claims

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

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

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

- State the specific reason(s) for the adverse benefit determination.
- Reference the specific plan provisions on which the determination is based.
- Describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary.
- Describe the plan's claims review procedures and the time limits applicable to such procedures, including 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.
- 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.

2. **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.

Send requests for appeals to:

BlueChoice HealthPlan
Appeals Department
Mail Code AX-325
P.O. 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. Request to cover services and supplies that are specifically excluded in the Contract will be treated as appeals; however, such requests aren't eligible for external review.

The following guidelines apply for each type of claim (including the appropriate claim about a cncurrent care decision), unless both parties agree to the extension:

A. Urgent Claims

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 complete the appeal process within 72 hours after we receive your appeal.

B. Pre-Service Claims

We must complete the appeal process within 30 calendar days after receiving the appeal.

C. Post-Service Claims

We must complete the appeal process 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.

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.

External Reviews

Request to cover services, benefits, or supplies that are excluded in the Contract 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:

- Your Physician has certified in writing that you have a Serious Medical Condition.
- The denial of coverage was based on our determination that the service is Investigational or Experimental and your Physician certifies:
  - Your condition is a serious disability, or you have a life-threatening disease; and
    - Standard health care services or treatments have not been effective in improving your condition.
    - Standard health care services or treatments are not medically appropriate.
    - The recommended or requested service or treatment is more beneficial than the standard health care service or treatment covered by us.
  - Medical and scientific evidence shows 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 asking 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 you as 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 something 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, conflicts with the statutes of the jurisdiction in which it is delivered is hereby amended to conform to the minimum requirements of such statutes. 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 that 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 while performing services for Members.

9.04 Relationship Between Parties

The Contract constitutes a Contract solely between the Employer and BlueChoice. BlueChoice 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 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.

9.07 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.

9.08 Legal Actions

You may not bring a lawsuit to recover benefits under this plan until you 60 days after the required written proof of loss has been submitted. 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.

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 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 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 6 p.m., Monday through Friday, to answer questions or discuss concerns.

Members may also write to:

BlueChoice HealthPlan
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 Members to be completely satisfied with the benefits and services associated with their BlueChoice coverage. However, 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 of South Carolina Inc. 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 a Member Services representative.

SECTION 12
DEFINITIONS

This section defines the terms used throughout this Certificate and is not intended to describe Covered and non-Covered Services. The terms defined in this section or otherwise in this Certificate shall have their defined meaning whenever they are capitalized in this Certificate. Any term in this Certificate which has a different medical and non-medical meaning, and which is undefined in this Certificate is intended to have the medical meaning.

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 leave of absence or temporary lay-off, unless the absence is due to a Health Status-related Factor and 2) be performing the normal duties of his or her occupation at one of the Employer's places of business or at 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 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 be on an Inpatient or Outpatient basis as determined by the Provider.

Allowed Amount or Allowable Charge: The maximum amount that we may pay for a Covered Service, except to the extent otherwise provided in this Certificate.

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.

Ambulatory Surgical Center: A facility that's licensed for Outpatient Surgery only and doesn't 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 RN. The facility must not be an office or clinic for the private practice of a Physician.

Approved Clinical Trial: 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:

- The study or investigation is federally approved or federally funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH)
  - CDC
  - Agency for Health Care Research and Quality
  - Centers for Medicare & Medicaid Services
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the VA
  - A qualified nongovernmental research entity identified in NIH guidelines for center support grants

  Or any of the following:
  - Department of Energy
  - DOD
  - VA

  If both of the following conditions are met:
  - The 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 NIH.
  - 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 FDA. The study or investigation is a drug trial that is exempt from having such an Investigational new drug application.

Authorize or Authorization: Prior approval by BlueChoice for a Provider of health care services to provide certain Covered Services to a Member. Such approval must be on file with BlueChoice before the service is considered Authorized.

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

Behavioral Therapy: Behavioral modification using applied behavioral analysis (ABA) techniques to target cognition, language, and social skills.

Benefit Period: A 12-month period that begins on the Effective Date of the group coverage or a calendar year. If the group coverage has a calendar year Benefit Period, the first Benefit Period may not be 12 months. It begins again each year on that date. Your Benefit Period is shown in your Schedule of Benefits.

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.

BlueChoice: Trade name for BlueChoice HealthPlan of South Carolina Inc.

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

Continuing Care Patient: An individual who, with respect to a Provider or facility, either (1) is undergoing a course of treatment for a Serious and Complex Condition from the Provider or facility, (2) is undergoing a course of institutional or Inpatient care from the Provider or facility, (3) 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, (4) is pregnant and undergoing a course of treatment for the pregnancy from the Provider or facility, or (5) is or was determined to be terminally ill (as determined by 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, 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 the Contract between the Employer and BlueChoice becomes effective.

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

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

Covered Service: A 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.

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're responsible for paying for 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's 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.

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

Effective Date: 12:01 a.m. on the date that coverage begins.

Emergency: An unexpected and usually dangerous situation that calls for immediate action.

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

Emergency Medical Condition: A medical condition, that includes a Behavioral Health condition, 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 any of 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, include:

- A medical screening examination that is within the capability of the Emergency department of a Hospital or a 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 SSA), 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 a Contract, by virtue of which Employees of the Employer or Members of the association, as the case may be, and their Dependents are eligible for the benefits described herein.

Essential Health Benefits: Items and services within the following benefit categories:
1. Ambulatory patient services.
2. Emergency services.
3. Hospitalization.
4. Maternity and newborn care.
5. Mental Health and Substance Use Disorder services, including Behavioral Health treatment.
6. Prescription drugs.
7. Rehabilitative and habilitative services and devices.
8. Laboratory services.
9. Preventive and wellness services and chronic disease management.
10. Pediatric services, including oral and vision care.

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

Fee Schedule: The negotiated amount to be paid by BlueChoice to Participating Providers 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 doesn't 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 their Dependents directly or through insurance, reimbursement, or otherwise.

Habilitation Services: Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings. All services must be provided by a licensed physical, occupational or speech therapist.

Health Insurance Coverage: Benefits for medical care provided directly through insurance, reimbursement or otherwise. It doesn't include benefits or coverage provided under:
- Coverage for accident or disability income insurance, or any combination of the two.
- Coverage issued as a supplement to liability insurance.
- Liability insurance, including general liability insurance and automobile liability insurance.
- Workers' Compensation or similar insurance.
- Automobile medical payment insurance.
- Credit-only insurance.
- Coverage for on-site medical clinics.
- Other similar insurance coverage that's specified in regulations where benefits for medical care are secondary or incidental to other insurance benefits.
- If offered separately:
    - Limited scope dental or vision benefits.
    - Benefits for Long-Term Care, nursing home care, home health care, community-based care or any combination of them.
    - Such other similar, limited benefits as specified in regulations.

- If offered as independent, noncoordinated benefits:
  - Coverage only for a specified disease or illness.
  - Hospital indemnity or other fixed indemnity insurance.
- If offered as a separate insurance policy:
  - Medicare supplemental health insurance.
  - Coverage to supplement coverage provided under the military, TRICARE or CHAMPUS.
  - Coverage to supplement coverage under a Group Health Plan.

Health Status Related Factor: Any one of these: health status; medical condition, including both physical and mental illnesses; claims experience; receipt of health care; medical history; Genetic Information; and evidence of insurability, including conditions arising out of domestic violence or disability.

Hospital: An acute-care facility that:
- Is licensed and operated according to the law.
- 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.
- Provides 24-hour nursing services by or under the supervision of RNs.

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

In-Network Coverage: Benefits for covered health 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 developmental disability, Behavioral Health illness or physical incapacity 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:

- 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.
- The service does not have scientific evidence that permits conclusions concerning the effective of the technology on health outcomes.
- The service has not been demonstrated to improve the net health outcome.
- The service has not been found to be as beneficial as any established alternatives.
- 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:

- FDA-approved market rulings.
- The United States Pharmacopoeia and National Formulary.
- The annotated publication titled, "Drugs, Facts, and Comparisons," published by J. B. Lippincott Company.
- Available peer-reviewed literature.
- Appropriate consultation with professionals and/or Specialists on a local and national level.

Legally Intoxicated: The Member's blood alcohol level was at or more than 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.

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

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 credit. The Maximum Payment will be one of the following as determined by us in our discretion. They include:

- The actual charge submitted to us for the service, procedure, supply or equipment by a Provider.
- An amount based upon the reimbursement rates established by the plan sponsor in its benefits checklist.
- An amount that has been agreed upon in writing by a Provider and us or a member of the Blue Cross Blue Shield Association.
- An amount established by us, based upon factors that include but are not limited to (1) governmental reimbursement rates applicable to the service, procedure, supply or equipment or (2) 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.
- 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.
- 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:

- Provides for child support with respect to a child of a Subscriber under the Contract or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law) and relates to benefits under the Contract.
- Enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act 0f 1993) with respect to a Group Health Plan.

Medically Necessary: 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:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate in terms of type, frequency, extent, site, and duration and considered effective for the patient's illness, injury, or disease
- Not primarily for the convenience of the patient, caregiver, Physician, or other health care Provider; or
- 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 use 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.
- "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.
- Our use of, including but not limited to, corporate administrative medical policies, Technology Evaluation Center 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.

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

Mental Health: Conditions defined, described, or classified as psychiatric disorders or conditions in the latest publication of The American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders."

Minimum Essential Coverage: Any of:

- Coverage under certain government-sponsored plans.
- Employer-sponsored plans, with respect to any Employee.
- Plans in the individual market.
- Grandfathered health plans.
- Any other health benefits coverage, such as a state health benefits risk pool, as recognized by the Health and Human Services secretary.

Minimum Essential Coverage doesn't include Health Insurance Coverage consisting of excepted benefits, such as dental-only coverage.

Multi-disciplinary Pain Management Program: A program that includes Physicians of different specialties and nonPhysician 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.

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.

Out-of-Pocket Limit: The most you pay 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.

Outpatient: A Member who receives services or supplies in a setting that doesn't require an Admission or an overnight stay.

Participating: The status of a Provider of Covered Services who has entered into a written agreement with BlueChoice to provide Covered Services to Members and to join BlueChoice's Network of Providers. The Participating status of a Provider may change from time to time. Providers who take part in the BlueCard Program are 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, that the FDA has determined to be safe and effective and that 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:

- Syringes and related supplies for conditions such as diabetes.
- 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: A facility, Hospital, Skilled Nursing Facility, Rehabilitation/Habilitation Facility, Mental Health or Substance Use facility, Residential Treatment Center, Physician, psychologist or other Mental Health clinicians, clinic or 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:

- Durable Medical Equipment suppliers.
- Independent clinical laboratories.
- Occupational, Physical and Speech therapists.
- Pharmacies.
- Home health care Providers.
- Hospice services Providers.
- Behavioral Health Providers.

Qualified Health Plan: A health plan that has been certified by the U.S. Department of Health and Human Services (HHS) to be offered through the Marketplace.

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 that has a written agreement with BlueChoice, 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.

Rehabilitation Services: Health care services that help a person improve skills and functioning that have been lost or impaired due to an illness or injury. These services may include physical and occupational therapy and speech therapy in a variety of Inpatient and/or Outpatient settings. All services must be provided by a licensed physical, speech or occupational therapist.

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

- It maintains permanent and full-time Facilities for bed care of resident patients.
- It has the services of a psychiatrist (addictionologist, when applicable) or Physician extender available at all times and is responsible for diagnostic evaluation, provides face-to-face evaluation services with documentation a minimum of once per week and PRN as indicated.
- It has a Physician or RN present on-site who is in charge of patient care along with one or more RNs or LPNs onsite 24/7.
- It keeps a daily medical record for each patient.
- It 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.
- It is operating lawfully as a Residential Treatment Center in the area where it is located.

Schedule of Benefits: The pages issued as an attachment to this Certificate that specify the amount of coverage provided, applicable Copayments, Coinsurance, Deductibles, and limitations.

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 (1) is life-threatening, degenerative, potentially disabling or congenital and (2) requires specialized medical care over a prolonged period.

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 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:

- It maintains permanent and full-time facilities for bed care of resident patients
- It always has the services of a Physician available.
- It has a RN or Physician on full-time duty who's in charge of patient care, along with one or more RNs or LPNs always on duty.
- It keeps a daily medical record for each patient.
- It 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.
- It is operating lawfully as a nursing home 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 abuse.

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. It also includes teeth that have been restored to normal function.

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: The continued use, abuse and/or dependence of legal or illegal substance(s), despite significant consequences or marked problems associated with the use as defined, described or classified in the latest publication of the American Psychiatric Association's, "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, including the placement of casts; and (3) other procedures as reasonable and as approved by us. This includes the usual, necessary and related preoperative and postoperative care.

Telemedicine: Medical care provided 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 in which 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: A level of coverage specified on the Prescription Drug List with respect to Prescription Medication. The Prescription Drug List includes drugs on different Tiers, each with its own Copayment and/or Coinsurance levels. Drug are chosen for each level based on their value, which takes into consideration how well they work and also their cost.

To Stabilize: With respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or, with respect to an Emergency.

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

Waiting Period: The period that must pass before you or your family members are eligible to be covered for benefits under the terms of the Contract with your Employer.