MASTER GROUP APPLICATION

Application is hereby made for Coverage as set forth in the attached BlueChoice® HealthPlan of South Carolina, Inc. Contract.

EMPLOYER INFORMATION

FULL LEGAL NAME OF EMPLOYER: ROGERS TOWNSEND

ADDRESS OF EMPLOYER: 1221 MAIN STREET, 14TH FLOOR
COLUMBIA, SC 29201

EMPLOYEE AND DEPENDENT INFORMATION

CLASSIFICATION OF ELIGIBLE EMPLOYEES:

FULL TIME, ACTIVELY AT WORK, EMPLOYEES WORKING AT LEAST 30 HOURS PER WEEK

PERIOD OF CONTINUOUS EMPLOYMENT AS PRE-REQUISITE TO ELIGIBILITY:

FIRST OF THE MONTH FOLLOWING 30 DAYS FROM DATE OF HIRE NOT EXCEDDING 90 DAYS

CLASSIFICATION OF ELIGIBLE DEPENDENTS:

SPOUSE, DEPENDENT CHILDREN UP TO AGE 26 YEARS REMOVED AT END OF THE MONTH
For purposes of eligibility for coverage under this Contract, a dependent child is the Subscriber's natural child, adopted child, foster child, step child or child for whom the Subscriber has legal custody or legal guardianship and who is under 26 years of age.

BENEFIT PROVISIONS

DESCRIPTION OF WAIVED BENEFITS:

NONE

BENEFIT PERIOD:

CONTRACT YEAR

TERMINATION RULE:

END OF MONTH

PARTICIPATION AND CONTRIBUTION REQUIREMENTS

- Employer Contribution being at least 70% toward single.
- 75% of all eligible employees must enroll with BlueChoice HealthPlan.

EMPLOYER'S SIGNATURE

Effective date of coverage under this application shall be 12:01 a.m., Eastern Time on July 1, 2018 at the address indicated above. Such Coverage will continue until terminated in accordance with the provisions of the Contract between the Employer and the Corporation. It is understood and agreed that the Employer shall cause to be paid to the Corporation, in advance, the Prepaid Fee specified in Appendix A of the Contract. This Prepaid Fee is made on behalf of the Employer's employees who meet the eligibility requirements specified in this application and who elect to be covered by the Corporation. This application shall form part of the Contract issued by the Corporation.

The employer may accept this Contract either by signature of this Master Group Application or by making the required Prepaid Fees to the Corporation. Such acceptance renders all terms and provisions hereof binding on the Corporation and the Employer.

ROGERS TOWNSEND

By: _____
(Authorized Signature)

Title: _____

Date: _____

BLUECHOICE HEALTHPLAN OF SOUTH CAROLINA, INC.

By: Timothy L. Vaughn
(Authorized Signature)

Title: **President and Chief Operating Officer**

Date: **July 1, 2018**

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APPENDIX A

Premium shall be as follows:

Stated As Monthly Amounts

Types of Membership

Employee:	$584.00
Employee/Spouse:	$1,158.75
Employee/Children:	$1,088.00
Family:	$1,663.50

Initial charges shall be payable in advance of the Contract Effective Date. Subsequent Premium shall be payable on or before the same date of each month thereafter. In no event shall coverage hereby applied for become effective until payment of the initial Premium is received by the Corporation.

The Corporation may change the monthly Premium whenever any benefit under the Contract is changed by amendment or as of any monthly due date upon giving 31 days prior written notice to the Employer.

Premium for Coverage Added

When a Subscriber or Dependent is added to the group's benefit plan under this Contract, the effective date of any change to the amount of the Premium due for coverage will be effective as follows.

1. For coverage added on or before the 15th day of the month, the new Premium is effective as of the first day of that month.
2. For coverage added on or after the 16th day of the month, the new Premium is effective as of the first day of the following month.

Premium for Coverage Terminated

When a Subscriber or Dependent is terminated from the group's benefit plan under this Contract, the effective date of any change to the amount of the Premium due for coverage will be effective as follows.

1. For coverage terminated on or before the 15th day of the month, the Premium is due through the last day of the month prior to termination.
2. For coverage terminated on or after the 16th day of the month, the Premium is due through the last day of the month of termination.

This provision does not apply to the effective date of an added or terminated Subscriber or Dependent with respect to eligibility for benefits under this Contract. Such eligibility for benefits is determined by the date on which the Employee or Dependent qualifies as or loses the status of an eligible Subscriber or Dependent under the terms of this Contract.

BlueChoice Advantage Plus High Deductible Health Plan
MASTER GROUP CONTRACT

This agreement is entered into by and between BlueChoice® HealthPlan of South Carolina, Inc., 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 BlueChoice Advantage Plus HDHP to those employees eligible for healthcare coverage as part of an employee benefit plan or program, and

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, and

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.

This Contract may not be modified, amended, or changed in any manner whatsoever, except in writing, signed by the Chief Operating Officer of the Corporation. No employee, agent, or other person is authorized to amend, modify, or otherwise change this Contract in such a manner as to expand the scope of Coverage or the conditions of eligibility, enrollment, or participation with the Corporation unless in writing and signed by the Chief Operating Officer of 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 agreement between the parties.

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

I.02 Election of Coverage

1. Any Employee eligible for Coverage may elect Coverage for himself or herself and all eligible Dependents by completing and filing with the Employer a Notice of Election. 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 Late or Special Enrollment.

2. The Employer shall furnish to the Corporation a list of eligible Employees and Dependents to be Covered, together with such data, other than evidence of insurability, 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, if the Corporation offers Coverage in the large group market in connection with a group health plan, 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 large 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 Prepaid Fee due date, unless the full Prepaid Fee is received by the Corporation at its home office no later than the 30th day after its due date. The Contract shall continue in force during that 31 day period and the Employer is liable for the full Prepaid Fee for this period.

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, or with respect to Coverage of a Member, fraud or intentional misrepresentation by the Member or the Member's representative. If the fraud or intentional misrepresentation is made by a person with respect to any person's prior health condition, the Corporation has the right also to deny Coverage to that person or to impose as a condition of continued Coverage the exclusion of the benefits for the condition misrepresented.

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 this particular type of Coverage, provided the Corporation:

      1) provides notice to each Employer providing Coverage of this type and the Members 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 of this type, the option to purchase any other Health Insurance Coverage currently being offered by the Corporation to a group health plan; and
      3) the Corporation 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 state, if:

      1) notice 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; and

2) all Health Insurance Coverage issued or delivered in this state in such 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. In the event the Employer notifies the Corporation that coverage of an Employee is to be terminated, or in the event this Contract is canceled by the Employer or non-renewed by the Corporation, the Coverage respecting such Employee and all of his or her Dependents automatically terminates on the date specified by the Employer or on the date of non-renewal, as applicable unless otherwise indicated in the Master Group Application and in this Contract. Retroactive terminations may be accepted if the terminated Employee had no benefit payments during such retroactive period. The retroactive period is limited to no more than 60 days. If benefits were paid during such period, Premium are then due and payable through the month in which the benefits were paid.

2. Employees may be considered as remaining in active employment for purposes of Coverage under this Contract during a disability leave of absence for a period not to exceed 90 days from the date of cessation of active work or, for a qualified Employee, during a leave pursuant to the Family and Medical Leave Act of 1993.

3. If an Employee on leave pursuant to the Family and Medical Leave Act fails to pay the Employee portion of the Prepaid Fee within a 31 day grace period and his or her Coverage ends, the Coverage of the Employee will be reinstated without a new Waiting Period provided the Employee returns to work immediately after the leave period, re-enrolls, and pays the applicable portion of the current Prepaid Fee within thirty-one days of such return to work.

SECTION III
COMPLIANCE WITH STATUTES

III.01 Compliance with Americans With Disabilities Act

The Corporation shall comply with a good faith interpretation of the Americans With Disabilities Act of 1990 with regard to its provision of benefits and services under this Contract.

III.02 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 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.

SECTION IV
GENERAL PROVISIONS

IV.01 Right to Modify

The Corporation may modify this Contract at the time of Coverage renewal. 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 or to an Employee 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.

IV.02 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 such statement shall be used in defense of a claim hereunder unless it is contained in a written application signed by such party against whom such defense is asserted and a copy of such statement is or has been furnished to the Member or the Member's representative.

3. Payment to any degree greater than as specified in this Contract will be made only at the discretion of the Corporation and in accordance with the Corporation's policies and procedures.

IV.03 Identification Card and Certificate of Coverage

The Corporation shall issue each Employee Covered hereunder an Identification 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. Identification 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**.**

IV.04 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 Identification Cards of all Members who terminate coverage with the Corporation for whatever reason during the Benefit Period.

IV.05 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.

IV.06 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.

IV.07 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 within the geographic area served by a Host Blue/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

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.

F. Blue Cross Blue Shield Global® Core

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 Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists 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, Members will typically have to pay the providers and submit the claims yourself 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 deductibles, coinsurance, etc. In such cases, the hospital will submit Member claims to the service center to initiate claims processing. However, if Member paid in full at the time of service, the Member must submit a claim to receive reimbursement for Covered Services. Members must contact us to obtain precertification for non-emergency inpatient services.

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require 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 Core 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 Core 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 us, the service center or online at www.bcbsglobalcore.com. If Members need assistance with your claim submission, they 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.

IV.08 Medical Loss Ratio

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

IV.09 Summary of Benefits and Coverage

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

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The holder of this Policy is a member of BlueCross® BlueShield® of South Carolina and is entitled to vote in person or by proxy at any and all meetings of said Company. This is a non-assessable Policy and the Policyholder 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 OPEN ACCESS INSURANCE POLICY

BLUECROSS BLUESHIELD 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:	ROGERS TOWNSEND, hereinafter called the Employer
GROUP CLIENT NUMBER:	00408*HDHP
POLICY EFFECTIVE DATE:	July 1, 2018

In consideration of the Application made by the Employer listed above, a copy of which is attached hereto and made part of this Policy, 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 Policy, for a period of one year beginning at 12:01 A.M. eastern time, on the date indicated above, hereinafter called the Policy Effective Date and from year-to-year thereafter, unless this Policy is terminated as provided herein. The Premium shall be due and payable by the Employer in advance of the Policy Effective Date and thereafter as provided herein. This Policy 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 Policy, 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 Policy, when combined with an HMO contract, provides comprehensive coverage. This Policy covers all eligible enrolled persons according to the terms described within this Group Medical Open Access Plan.

Scott Graves
President, BlueCross BlueShield Division

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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 Policy. The Administrator shall collect Premiums and process all claims occurring under this Policy and pay benefits when due in accordance with the terms, conditions, limitations and exclusions of this Policy.

IMPORTANT FOR BENEFITS. The Company has arranged for the Administrator to conduct Authorization review for certain Hospital Admissions. The Enrollee must initiate the review process by notifying the Administrator and complying with specific Authorization requirements to qualify for maximum benefits under this Policy. 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 shall be eligible for Coverage on or after the Policy Effective Date provided such Employee has completed the period of continuous employment commonly referred to as the Waiting Period with the Employer. Neither an Employee nor the Employee's Dependents shall be Covered until the Employee is Actively At Work.

ELECTION OF COVERAGE. Any Employee eligible for Coverage may elect Coverage for himself or herself and all eligible Dependents by completing and filing with the Employer a Notice of Election. 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 Late or Special Enrollment.

The Employer shall furnish to the Administrator a list of eligible Employees and Dependents to be Covered, together with such data, other than evidence of insurability, as may be required by the Administrator as a prerequisite to Coverage under this Policy.

SECTION 2
NONRENEWAL OR DISCONTINUATION OF THIS POLICY

GENERAL PROVISIONS. Except as provided in this section, if the Company offers Coverage in the large group market, 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 Policy or the Company has not received timely Premium payments. This Policy, and all certificates issued thereunder shall automatically terminate without notice on the 31st day following a Premium due date, unless the full Premium Fee is received by the Administrator at its home office no later than the 30th day after its due date. The Policy shall continue in force during that 31 day period and the Employer is liable for the full Premium for this period.

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 Policy, or with respect to coverage of a person, fraud or intentional misrepresentation by the person or the person's representative. If the fraud or intentional misrepresentation is made by a person with respect to any person's prior health condition, the Administrator on behalf of the Company, has the right also to deny coverage to that person or to impose as a condition of continued coverage the exclusion of the condition misrepresented.

3. **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 this particular type of Coverage, if it:

      1) gives notice to each Employer providing Coverage of this type 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 of this type, the option to purchase any other Health Insurance Coverage currently being offered by the Company to a group health plan; and
      3) the Company 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 this state, if:

      1) notice 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; and
      2) all Health Insurance Coverage issued or delivered in this state in such 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 this particular type of 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. In the event the Employer notifies the Company that Coverage of an Employee is to be terminated, or in the event this Policy is canceled by the Employer or non-renewed by the Company, the Coverage respecting such Employee and all of his Dependents automatically terminates on the date specified by the Employer or on the date of non-renewal, as applicable unless otherwise indicated in the Master Group Application and in this Section. Retroactive terminations may be accepted if the terminated Employee had no benefit payments during such retroactive period. The retroactive period is limited to no more than 60 days. If benefits were paid during such period, Premiums are then due and payable through the month in which the benefits were paid.

2. Employees may be considered as remaining in active employment for purposes of Coverage under this Policy during a disability leave of absence for a period not to exceed 90 days from the date of cessation of active work or, for a qualified Employee, during a leave pursuant to the Family and Medical Leave Act of 1993.

3. If an Employee on leave pursuant to the Family and Medical Leave Act fails to pay the Employee portion of the Premium Fee within a 31 day grace period and coverage ends, the Coverage of the Employee will be reinstated without a new waiting period provided the Employee returns to work immediately after the leave period, re-enrolls and pays the appropriate portion of the then current Premium within 31 days of such return to work.

NOTIFICATION

1. 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 Policy.

2. The Employer shall be responsible to collect all Identification Cards of all Enrollees who terminate Coverage with the Company for whatever reason during the Benefit Period.

SECTION 3
PREMIUM PROVISIONS

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 Policy Month's Premium shall be charged for Enrollees whose Enrollment Date falls on or before the 15th of that Policy Month. No Premium shall be charged for Enrollees whose Enrollment Date falls after the 15th of that Policy Month.

CHANGES IN ENROLLMENT. From time to time new Employees may be added to this Policy. The Policyholder shall notify the Administrator in writing within 30 days of the person's Enrollment Date, effective date of termination, or other changes to enrollment. Such changes shall be reported on a monthly basis. Retroactive adjustments may be made for any changes to enrollment which are not known at the time Premium is calculated. The retroactive period is limited to no more than 60 days.

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 Policyholder at least 31 days prior to the effective date of the change. Payment of Premium shall constitute the policyholder'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.

PAYMENT OF PREMIUMS. Premiums required by this Policy 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 Policy. Subsequent Premiums are due and payable on the first of each Policy Month thereafter that this Policy is in effect. Premiums for this Policy must be paid by the Policyholder from the Policyholder's funds or from funds contributed by the insured persons, or from both.

At any time, the Company may notify the group 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 Company needs to refund money to the group or in situations involving a medical loss ratio rebate (see the **Medical Loss Ratio** section in the *General Provisions section*). The Company is under no obligation to waive the group's premium and the fact that it may do so does not obligate it waive premium in the future.

Payment of premium by the Employer shall constitute acceptance of the terms of this contract (including this Certificate of Coverage and the Schedule of Benefits) regardless of the absence of the Employer's signature.

SECTION 4
STANDARD PROVISIONS

GRACE PERIOD. A grace period of 31 days will be granted for payment of any Premium due (except the first Premium). During the grace period this Policy will remain in force, unless the Policyholder has given the Company written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the Policy. In no event shall the grace period extend beyond the date this Policy terminates.

INCONTESTABILITY. The validity of the Policy 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 Policy 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 policy or upon other provisions in the Policy.

ENTIRE CONTRACT. A copy of the application, if any, of the Policyholder must be attached to the Policy when issued. All statements made by the Policyholder 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 Policyholder 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 twenty days after the occurrence or commencement of any loss covered by the policy. 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 Policyholder 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 fifteen days after the Administrator received notice of any claim under the policy, the person making the claim is considered to have compiled with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claims is made.

TIME PAYMENT OF CLAIMS. All benefits payable under the Policy will be paid not more than 60 days after receipt of proof of the loss.

LEGAL ACTION. No action at law or in equity may be brought to recover on the Policy before the expiration of 60 days after written proof of loss has been filed in accordance with the requirements of the Policy 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.

SECTION 5
GENERAL PROVISIONS

BASIS FOR COVERAGE. This Policy has been issued to the Policyholder on behalf of the eligible Employees and their eligible Dependents. The eligibility requirements, Policy Effective Date, Enrollee's effective date, and termination date of coverage stated in this Policy, are coincident to, and consistent with, the provisions set forth in the HMO Contract. The Employees to be covered, any Employee waiting period which applies, Premium classes, and the plan of benefits, are in accordance with the Policyholder's group application to the Company. Employee and Dependent Premium shall be on a contributory or non-contributory basis as specified in the Policyholder's group application to the Company.

CHANGES. No changes in this Policy 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 Policy. No agent has the authority to change this Policy or waive any of its provisions.

RECORDS. The Policyholder shall give the Administrator all information and proof as the Administrator may reasonably require with regard to any matters pertaining to this Policy. All documents given to the Policyholder by Members in connection with their coverage, together with the Policyholder's payroll and any other records which may have a bearing on the coverage provided under this Policy, 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 Policy. 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 Policy 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 Policy which, on its effective date, 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.

REPLACEMENT COVERAGE. If this Policy replaced a prior plan of the Policyholder, all eligible persons who were validly covered under that plan on its termination date will be covered on the Policy Effective Date of this Policy, provided such persons are enrolled for coverage. In this replacement situation, coverage will be provided as follows:

1. **Deductible Credit -** Eligible Expenses incurred before the discontinuance of the prior plan, and which were applied toward the prior plan deductible will be credited to the extent such charges meet the Deductible requirements under this Policy.

2. **Total Disability -** If an Enrollee is Totally Disabled on the date of discontinuance of the prior plan and entitled to its extension of benefits, benefits under this Policy related to the disabling condition will be reduced by the amount paid by the prior plan under its extension of benefits.

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 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.

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.

BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services within the geographic area served by a Host Blue/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.

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.

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.

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.

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.

Blue Cross Blue Shield Global® Core

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 Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists 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, Members will typically have to pay the providers and submit the claims yourself 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 deductibles, coinsurance, etc. In such cases, the hospital will submit Member claims to the service center to initiate claims processing. However, if Member paid in full at the time of service, the Member must submit a claim to receive reimbursement for Covered Services. Members must contact us to obtain precertification for non-emergency inpatient services.

- **Outpatient Services**

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require 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 Core 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 Core 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 us, the service center or online at www.bcbsglobalcore.com. If Members need assistance with your claim submission, they 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.

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

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

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BlueChoice HealthPlan
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Non-Grandfathered

Schedule of Benefits
BlueChoice Advantage Plus HDHP℠
Rogers Townsend

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

In order to receive In-Network benefits, all services must be provided by a BlueChoice HealthPlan Participating Provider. This applies to each individual service unless otherwise noted. All inpatient and outpatient facility admissions must be authorized by BlueChoice HealthPlan in order to be covered. Benefits are subject to all terms, conditions, limitations, and exclusions outlined in the Contract.

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Deductible per Benefit Period		
Individual Coverage	$3,250	$4,500
Family Coverage	$6,500	$9,000
Out-of-Pocket Maximum per Benefit Period (comprised of deductible, coinsurance and all copays) (Embedded MOOP: All family members can contribute with no one member contributing more than the Individual amount.)		
Individual Coverage	$3,250	$10,000
Family Coverage	$6,500	$20,000

Services other than Mental Health and Substance Use Disorders

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS (Member must pay balance of Provider's Charge)
Physician Care	**(Routine/preventive care covered)**	**(Routine/preventive care covered)**
Office services (All Other)	Deductible	Deductible, then 40%
Mandated Preventive Care	$0	Not Covered
Other Routine Services	(Not subject to deductible or copayment)	
GYN Exam Routine screening mammograms Routine screening colonoscopies	$0	Deductible, then 40%
Hospital/Facility Services	**(Authorization required)**	**(Authorization required)**
Inpatient admission (including maternity)	Deductible	Deductible, then 40%
Skilled Nursing Facility	Deductible	Deductible, then 40%
Long-term Acute Care Facility	Deductible	Deductible, then 40%

In-Network Covered Services are underwritten by BlueChoice HealthPlan of South Carolina, Inc. Out-of-Network Covered Services are underwritten by BlueCross BlueShield of South Carolina and administered by BlueChoice HealthPlan of South Carolina, Inc. BlueCross BlueShield of South Carolina and BlueChoice HealthPlan are independent licensees of the Blue Cross and Blue Shield Association.

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Schedule of Benefits
BlueChoice Advantage Plus HDHP℠
Rogers Townsend

In order to receive In-Network benefits, all services must be provided by a BlueChoice HealthPlan Participating Provider. This applies to each individual service unless otherwise noted. All inpatient and outpatient facility admissions must be authorized by BlueChoice HealthPlan in order to be covered. Benefits are subject to all terms, conditions, limitations, and exclusions outlined in the Contract.

Services other than Mental Health and Substance Use Disorders

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS (Member must pay balance of Provider's Charge)
Outpatient/Ambulatory Care Facilities (Authorization required)		
All services (including maternity)	Deductible	Deductible, then 40%
Emergency room services	Deductible	Same as In-Network
Ambulatory Surgical Center	Deductible	Deductible, then 40%
Urgent care	Deductible	Deductible, then 40%
Prescription Medicine & Specialty Pharmaceuticals Certain Prescription Medicine may require prior authorization or have dosage limits	Deductible	Not Covered
Other Services		
Ambulance	Deductible	Deductible, then 40%
Behavioral Therapy (ABA) for Autism Spectrum Disorder	Deductible	Not Covered
Dental Services due to accidental injury	Deductible	Deductible, then 40%
Durable Medical Equipment (DME)	Deductible	Deductible, then 40%
Home Health	Deductible	Deductible, then 40%
Hospice	Deductible	Deductible, then 40%
Initial Prosthetic Appliances	Deductible	Deductible, then 40%
Medical Supplies	Deductible	Deductible, then 40%
Occupational Therapy	Deductible	Deductible, then 40%
Outpatient Private Duty Nursing	Deductible	Deductible, then 40%
Physical Therapy	Deductible	Deductible, then 40%
Speech Therapy	Deductible	Deductible, then 40%
Chiropractic Services		
Manipulation	Deductible	Not Covered
All Other Services	Deductible	Not Covered
Covered transplants will be treated the same as any other medical condition. Services must be provided at a BlueChoice HealthPlan participating facility or a Blues Distinction for Transplant designated facility.		

In-Network Covered Services are underwritten by BlueChoice HealthPlan of South Carolina, Inc. Out-of-Network Covered Services are underwritten by BlueCross BlueShield of South Carolina and administered by BlueChoice HealthPlan of South Carolina, Inc. BlueCross BlueShield of South Carolina and BlueChoice HealthPlan are independent licensees of the Blue Cross and Blue Shield Association.

Non-Grandfathered

Schedule of Benefits
BlueChoice Advantage Plus HDHP℠
Rogers Townsend

In order to receive In-Network benefits, all services must be provided by a BlueChoice HealthPlan Participating Provider. This applies to each individual service unless otherwise noted. All inpatient and outpatient facility admissions must be authorized by BlueChoice HealthPlan in order to be covered. Benefits are subject to all terms, conditions, limitations, and exclusions outlined in the Contract.

Mental Health & Substance Use Disorders
(Companion Benefit Alternatives, Inc. (CBA) must authorize inpatient and outpatient facility admissions in advance. On behalf of BlueChoice HealthPlan, CBA manages behavioral health and substance abuse benefits for our members and their dependents. CBA is a separate company. Call CBA at 1-800-868-1032.)

BENEFITS	**In-Network MEMBER PAYS**	**Out-of-Network MEMBER PAYS** (Member must pay balance of Provider's Charge)
Inpatient Hospital Facility Services	Deductible	Deductible, then 40%
Inpatient Physician Services	Deductible	Deductible, then 40%
Outpatient Facility Institutional Services	Deductible	Deductible, then 40%
Outpatient Facility Professional Services	Deductible	Deductible, then 40%
Office Professional Services (does not require prior authorization)	Deductible	Deductible, then 40%

In-Network Covered Services are underwritten by BlueChoice HealthPlan of South Carolina, Inc. Out-of-Network Covered Services are underwritten by BlueCross BlueShield of South Carolina and administered by BlueChoice HealthPlan of South Carolina, Inc. BlueCross BlueShield of South Carolina and BlueChoice HealthPlan are independent licensees of the Blue Cross and Blue Shield Association.

BlueChoice HealthPlan
South Carolina
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Non-Grandfathered

Schedule of Benefits
BlueChoice Advantage Plus HDHP℠
Rogers Townsend

In order to receive In-Network benefits, all services must be provided by a BlueChoice HealthPlan Participating Provider. This applies to each individual service unless otherwise noted. All inpatient and outpatient facility admissions must be authorized by BlueChoice HealthPlan in order to be covered. Benefits are subject to all terms, conditions, limitations, and exclusions outlined in the Contract.

MAXIMUMS	
Occupational Therapy	20 visits per Benefit Period
OP Private Duty Nursing	60 visits per Benefit Period
Physical Therapy	20 visits per Benefit Period
Skilled Nursing Facility	120 days per Benefit Period
Speech Therapy	20 visits per Benefit Period
Benefit Period	Contract Year

The following benefits are covered outside of the BlueChoice Advantage Plus HDHP benefits.

BENEFITS	MEMBERS PAYS
Employee Assistance Program (EAP) Services	
Individual & Family Counseling (visits 1-6)	$0
Life Management Services (6 visits)	$0
Benefits are provided under an agreement between First Sun EAP and the Employer. First Sun EAP is a separate company that does not offer BlueChoice HealthPlan products. These services are offered by First Sun EAP, not BlueChoice HealthPlan. BlueChoice HealthPlan has no responsibility for these services. 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.	

- Personal Health Assessment

∗ **No annual or lifetime dollar limits apply for essential health benefits.**

In-Network Covered Services are underwritten by BlueChoice HealthPlan of South Carolina, Inc. Out-of-Network Covered Services are underwritten by BlueCross BlueShield of South Carolina and administered by BlueChoice HealthPlan of South Carolina, Inc. BlueCross BlueShield of South Carolina and BlueChoice HealthPlan are independent licensees of the Blue Cross and Blue Shield Association.

CERTIFICATE OF COVERAGE

BlueChoice Advantage Plus High Deductible Health Plan

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

BlueChoice® HealthPlan
Post Office Box 6170
Columbia, SC 29260-6170

www.BlueChoiceSC.com

803-786-8476
1-800-868-2528

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INTRODUCTION

No annual or lifetime dollar limits apply for essential health benefits.

Point Of Service Benefits. The BlueChoice Advantage Plus High Deductible Health Plan (HDHP) is an open access point-of-service product**.** That means Members decide at the time they need medical care whether they will go to a healthcare provider within BlueChoice HealthPlan's network, a Participating 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 BlueChoice Advantage Plus HDHP is automatically entitled to In-Network and Out-of-Network benefits as described below.

> **In-Network benefits** apply when you receive Covered Services from a BlueChoice HealthPlan 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 healthcare professional within BlueChoice HealthPlan's network of Providers. Please see your Schedule of Benefits for this information. BlueChoice HealthPlan's Participating Providers handle all of the paperwork, so you have no bills or claim forms to submit. BlueChoice HealthPlan of South Carolina, Inc. underwrites these benefits.
>
> **Out-of-Network benefits** apply when you receive Covered Services from any licensed Provider outside of the BlueChoice HealthPlan 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 in order to receive benefits. You can also be billed for any amount in excess of the Reasonable and Customary Fee Schedule. BlueCross® BlueShield® of South Carolina underwrites these benefits and has arranged for BlueChoice HealthPlan to serve as the administrator of the Out-of-Network benefits.

High Deductible Health Plan. BlueChoice Advantage Plus HDHP is also a high deductible health plan. That means Members must pay a set amount for Covered Services (the Deductible) before BlueChoice HealthPlan will begin paying benefits for Covered Services. This amount is shown on your Schedule of Benefits.

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

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

The BlueCard® Program. The BlueCard Program is a national program in which all Blue Cross and Blue Shield Licensees participate, including BlueChoice HealthPlan. This national program enables BlueChoice HealthPlan Members living or traveling outside of South Carolina to receive the highest level of benefits when they obtain services from any physician or hospital designated as a BlueCard PPO provider. Doctors and hospitals in the BlueCard Program are considered to be Participating Providers.

CERTIFICATE OF COVERAGE

This Certificate of Coverage is part of a group contract that is a legal document between BlueChoice® HealthPlan and the Employer. The Master Group Contract, this Certificate of Coverage, the Schedule of Benefits, the Master Group Application, the Notices of Election and attached amendments, addenda, riders, or endorsements, if any, constitute the entire Contract between both parties.

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

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

This certificate replaces and supersedes any certificate that previously may have been issued to you by BlueChoice HealthPlan and governs Covered Services rendered after the effective date of the Contract. Any subsequent certificates issued to you by BlueChoice HealthPlan 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.

Important For Benefits. Prior Authorization (approval for services) from BlueChoice HealthPlan is required for all non-emergency Hospital admissions. The admitting Physician, the Hospital or someone acting on your behalf must initiate the authorization process by notifying BlueChoice HealthPlan prior to admission and complying with specific Authorization requirements in order to qualify for maximum benefits. Failure to do so may result in denial of benefits.

Only Medically Necessary health services are Covered under the 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, sickness or mental illness, does not mean that the procedure or treatment is Covered under the Contract. BlueChoice HealthPlan may, at its discretion, delegate authority to other persons or entities to provide services in regard to the Contract.

Benefits for all services are subject to the provisions of the Contract. In order to be Covered, services must be Medically Necessary and performed on or after the Member’s Effective Date and prior to cancellation of Coverage. Benefits are subject to all (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 Contract.

Benefits payable under the Contract are not assignable to a non-Participating Provider, unless determined otherwise by BlueChoice HealthPlan in its sole discretion. This means BlueChoice HealthPlan may send benefit payments to you and you will be responsible for paying the Provider.

SECTION 1
WHAT'S COVERED: IN-NETWORK SERVICES

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

1.01 Physician Services

Benefits are provided for preventive, diagnostic, and treatment services when such services are provided by Participating Physicians. This includes Medically Necessary office visits and medical or surgical care provided in a Participating Physician's office or a Participating Hospital, Alternate Facility, Long-Term Acute Care Facility, Skilled Nursing Facility or Rehabilitation Hospital. The following services are Covered Services.

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

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

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

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

1.02 Inpatient Facility Services

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

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

1.03 Maternity Care

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

1.04 Outpatient Facility Services

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

2. **Outpatient Laboratory, Radiology, Diagnostic and Therapeutic Services.** Services and supplies for laboratory, radiology and other diagnostic tests and therapeutic treatments are Covered Services when provided under the direction of a Participating Physician at a Participating Hospital or Participating Alternate Facility.

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

1.05 Physical, Speech and Occupational Therapy

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

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

1.05A Chiropractic Services

Benefits will be provided at the level shown in the Schedule of Benefits. Benefits are provided for office services provided by a chiropractor in connection with the detection and correction by manual means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of such nerve interference, where such interference is the result of or related distortion, misalignment or subluxation of, or in, the vertebral column. Maintenance care is not Covered.

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

1.06 Mental Health and Substance Use Disorders

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

1.07 Prescription Medication

Coverage for Prescription Medication is provided unless specifically excluded pursuant to Section 5. When Covered, benefits for Prescription Medication are provided when purchased at a Participating pharmacy and prescribed by a Participating Physician. This includes certain classes of over-the-counter drugs designated by BlueChoice HealthPlan as Prescription Medication. Benefits for a Covered Prescription Medication dispensed to a Member shall not exceed the quantity and benefit maximum, if applicable, as specified in the Schedule of Benefits. A list of Participating pharmacies can be found on the BlueChoice HealthPlan website.

Benefits are provided only for the most cost-effective Prescription Medication available at the time dispensed whenever medically appropriate and in accordance with all legal and ethical standards. Certain Prescription Medications require Prior Authorization and/or Step Therapy in order to be Covered, and have quantity limits as determined by BlueChoice HealthPlan.

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

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

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

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

1.08 Ambulance Services

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

1.09 Home Health Services and Outpatient Private Duty Nursing

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

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

1.10 Hospice Services

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

1.11 Transplants

1. Benefits are provided for Covered Services for certain human organ and tissue transplants, listed on the Schedule of Benefits. To be covered, such transplants must be provided from a human donor to a Member (the transplant recipient) and provided at a Designated Transplant Facility. All solid organ (complete organ or segmental, cadaveric or living donor) procurement services, including donor organ harvesting, typing, storage and transportation are covered.
2. The payment for charges for Covered Services incurred by a living donor are subject to the following:
    - A. When both the transplant recipient and the donor are Members, benefits will be provided for both.
    - B. When the transplant recipient is a Member and the donor is not, benefits will be provided for both.
    - C. When the transplant recipient is not a Member and the donor is, no benefits will be provided to either the donor or the recipient.
3. Transplants that are Experimental, Investigational or Unproven are not Covered Services. Transplants that are not Medically Necessary, as determined by the Corporation, are not Covered Services.
4. Benefits are provided on the same basis as any other condition or illness subject to the maximums stated in the Schedule of Benefits, if any.

1.12 Emergency and Urgent Care Services

Benefits are provided for services and supplies for stabilization and/or initial treatment of an Emergency Medical Condition provided on an outpatient basis at either a Hospital or an Alternate Facility. In order to be Covered, follow-up care must be provided by a Participating Physician.

Reimbursement for Out of Network Emergency Services will be based on the greatest of the following:

A. The Fee Schedule for Participating providers.
B. The Reasonable and Customary Fee Schedule.
C. The Medicare allowance.

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 HealthPlan. Follow-up care is a Covered Service when provided by a Participating Physician.

1.13 Prosthetics and Durable Medical Equipment

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

1. the initial purchase of artificial limbs, artificial eyes, and other Medically Necessary prosthetic devices made necessary as a result of injury or sickness. (Prosthetic devices replace a limb or body part.)
2. the rental or purchase, at the discretion of BlueChoice HealthPlan, of Durable Medical Equipment including, but not limited to, the following: braces, including necessary adjustments to shoes to accommodate braces (dental braces are excluded); oxygen and the rental of equipment for the administration of oxygen; standard wheelchairs; standard Hospital-type beds; and mechanical equipment necessary for the treatment of chronic or acute respiratory failure. Air-conditioners, humidifiers, dehumidifiers, personal comfort items, eyeglasses, hearing aids and deluxe appliances are excluded.

1.14 Medical Supplies

Covered supplies must be purchased at or under the direction of a Participating Physician. Benefits for medical supplies are limited to the following:

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

Supplies and equipment that have non-therapeutic uses are not Covered Services.

1.15 Dental Care For Accidental Injury

Dental services performed by a Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.) to natural teeth required because of accidental injury are Covered Services. For purposes of this benefit, an accidental injury is defined as an injury caused by a traumatic force such as a car accident or blow by a moving object. No benefits are provided for injuries that occur while the Member is in the act of chewing or biting. Only services directly related to the accidental injury are Covered Services. No Coverage is provided unless the dentist certifies to BlueChoice HealthPlan that services were performed to natural teeth that were injured as a result of an accident, and that the services were completed within six months of the accident. Services other than those provided during the initial visit must be Authorized by BlueChoice HealthPlan in order to receive benefits.

1.16 Benefits Mandated by State and/or Federal Law

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

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

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

    A. once as a base-line mammogram for a female who is at least 35 years of age but less than 40 years of age;
    B. once every two years for a female who is at least 40 years of age but less than 50 years of age;
    C. once a year for a female who is at least 50 years of age; or
    D. in accordance with the most recently published guidelines of the American Cancer Society.

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

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

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

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

7. **Cleft Lip and Palate**

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

   A. oral and facial surgery, surgical management and follow-up care;
   B. prosthetic treatment such as obdurators, speech appliances and feeding appliances;
   C. orthodontic treatment and management;
   D. prosthodontia treatment and management;
   E. otolaryngology treatment and management;
   F. audiological assessment, treatment, and management, including surgically implanted amplification devices; and
   G. physical therapy assessment and treatment.

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

8. **Autism Spectrum Disorder.** Any Member diagnosed with Autistic Spectrum Disorder at age eight or younger is eligible for this Coverage.

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

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

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

1.17 Preventive Services

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

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

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

1.18 Clinical Trials

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

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

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

1.19 Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area we serve, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. **BlueCard® Program**

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

When you receive Covered Services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

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

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

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

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 employer on your behalf, we will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

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 (Optional)

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

E. Blue Cross Blue Shield Global® Core

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

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. You must contact us to obtain precertification for non-emergency inpatient services.

- **Outpatient Services**

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

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

When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from us, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

1.20 Discount Services

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

SECTION 2
WHAT'S COVERED: OUT-OF-NETWORK SERVICES

Out-of-Network benefits apply when you receive Covered Services from any licensed Provider outside of the BlueChoice HealthPlan 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 in order to receive benefits. These benefits are paid based on the Reasonable and Customary Fee Schedule. BlueCross BlueShield of South Carolina underwrites these benefits and has arranged for BlueChoice HealthPlan to serve as the administrator of the Out-of-Network benefits.

2.01 Covered Health Services

Medical and surgical services provided by a Physician for the treatment of a sickness or injury including office visits and Hospital visits. Allergy testing and treatment, including test and treatment material (allergy serum).

2.02 Inpatient Facility Services

Room and board based on semi-private accommodations and related, ancillary and diagnostic services and supplies. Special care units are Covered when Medically Necessary. The admission must be Authorized in advance by BlueChoice HealthPlan except for an emergency admission.

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

2.03 Maternity Care

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

2.04 Outpatient Facility Services

1. **Outpatient Surgery**. Services and supplies for outpatient observation and surgery.
2. **Outpatient Laboratory, Radiology, Diagnostic and Therapeutic Services**. Services and supplies for laboratory, radiology, and other diagnostic tests and therapeutic treatments.

2.05 Ambulance Services

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

2.06 Home Health Services and Outpatient Private Duty Nursing

1. Benefits for home health services include part-time, intermittent nursing care by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) where appropriate, or physical, speech, or occupational therapy provided through a home health agency. Services by a home health aide are considered to be Custodial Care and are not Covered.
2. Benefits are provided for special or private duty nursing by a registered nurse or a licensed practical nurse when provided on an outpatient basis, and when such services are required for care and treatment that otherwise would require admission to a Hospital. Benefits for outpatient private duty nursing are limited to 60 days per Benefit Period.

2.07 Hospice Services

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

2.08 Medical Supplies

Covered supplies must be purchased at or under the direction of a Participating Physician. Benefits for medical supplies are limited to the following:

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

Supplies and equipment that have non-therapeutic uses are not Covered Services.

2.09 Prosthetics and Durable Medical Equipment

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

1. the initial purchase of artificial limbs, artificial eyes, and other Medically Necessary prosthetic devices made necessary as a result of injury or sickness. (Prosthetic devices replace a limb or body part.)
2. the rental or purchase, at the discretion of BlueChoice HealthPlan, of Durable Medical Equipment including, but not limited to, the following: braces, including necessary adjustments to shoes to accommodate braces (dental braces are excluded); oxygen and the rental of equipment for the administration of oxygen; standard wheelchairs; standard Hospital-type beds; and mechanical equipment necessary for the treatment of chronic or acute respiratory failure. Air-conditioners, humidifiers, dehumidifiers, personal comfort items, eyeglasses, hearing aids and deluxe appliances are excluded.

2.10 Transplants

1. Benefits are provided for Covered Services for certain human organ and tissue transplants, listed on the Schedule of Benefits. To be covered, such transplants must be provided from a human donor to a Member (the transplant recipient) and provided at a Designated Transplant Facility. All solid organ (complete organ or segmental, cadaveric or living donor) procurement services, including donor organ harvesting, typing, storage and transportation are covered.
2. The payment for charges for Covered Services incurred by a living donor are subject to the following:
   A. The medical and surgical expenses for care and treatment of a living donor are covered only if the donor and recipient are both covered by BlueChoice HealthPlan.
3. Transplants that are Experimental, Investigational or Unproven are not Covered Services. Transplants that are not Medically Necessary, as determined by the Corporation, are not Covered Services.
4. Benefits are provided on the same basis as any other condition or illness subject to the maximums stated in the Schedule of Benefits, if any.

2.11 Mental Health and Substance Use Disorders

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

SECTION 3
PROCEDURES FOR OBTAINING BENEFITS

With BlueChoice Advantage Plus HDHP, you have benefits for Covered Services provided by any licensed healthcare professional. For coverage at the In-Network benefit level, services must be received from a Provider in the BlueChoice HealthPlan network - a Participating Provider. Or, you may see a healthcare professional who is not in the BlueChoice HealthPlan 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.

3.01 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 Web site at www.BlueChoiceSC.com, or by calling 786-8476 in Columbia or 1-800-868-2528 when outside the Columbia area.

Enrolling for Coverage under BlueChoice Advantage Plus HDHP does not guarantee the availability of a particular Participating Provider on the list of Providers. This list of Participating Providers is subject to change.

3.02 Continuation of Care

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

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

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

3.03 Referral Health Services by Non-Participating Providers

If specific Covered Services cannot be provided by or through a Participating Provider, you are eligible for Coverage at the In-Network benefit level for Covered Services obtained through non-Participating Providers. These services must be Authorized in advance through referral documentation designated by BlueChoice HealthPlan and are subject to the provisions, limitations and exclusions of this Contract. It is your responsibility to obtain this required Authorization prior to receiving the services.

3.04 Prior Authorization

All inpatient and outpatient facility admissions, except for Emergency admissions, must be authorized in advance by BlueChoice HealthPlan. For emergency admissions, BlueChoice HealthPlan should be notified not later than 24 hours after the admission or the next working day if possible, or as soon as the patient conditions allows.

All inpatient and outpatient facility admissions for Mental Health and Substance Use Services must be Authorized by Companion Benefit Alternatives.

3.05 Concurrent Review

BlueChoice HealthPlan will conduct concurrent review of all inpatient admissions. BlueChoice HealthPlan will remain in contact with the treating Physician throughout the course of treatment to review requests for extension of benefits based on the Medical Necessity of a continued Hospital stay. Each requested extension will be reviewed on a case-by-case basis.

3.06 Authorization Does Not Guarantee Benefits

The fact that BlueChoice HealthPlan Authorizes services or supplies does not guarantee that all charges will be Covered. Benefit determination is made by BlueChoice HealthPlan in accordance with all of the terms, conditions, limitations and exclusions of this Contract – including eligibility and any applicable pre-existing condition exclusion.

3.07 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 HealthPlan ID card.
2. In an emergency, go directly to the nearest hospital.
3. To find names and addresses of nearby doctors and hospitals, visit the BlueCard Doctor and Hospital Finder or call BlueCard *Access* at 1-800-810-BLUE. This phone number can also be found on your Member identification card.
4. If you are admitted to the hospital, call BlueChoice HealthPlan for pre- authorization. (Refer to the phone number on the back of your BlueChoice HealthPlan ID card.)
5. When you arrive at the participating doctor's office or hospital, simply present your BlueChoice HealthPlan ID card. As a BlueChoice Advantage Plus HDHP Member, the doctor will recognize the PPO℠ logo.

After you receive care:

- You should not have to complete any claim forms.
- You should not have to pay up front for medical services other than the usual out-of-pocket expenses (non-covered services, deductible, copayment, and coinsurance).
- BlueChoice HealthPlan will send you a complete explanation of benefits.

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

SECTION 4
PARTICIPATING AND NON-PARTICIPATING PROVIDERS
HOW TO FILE A CLAIM

4.01 Participating Providers

Participating Providers have agreed with BlueChoice HealthPlan to do the following:

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

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

4.02 Non-Participating Providers

Non-Participating Providers may agree to file claims directly to BlueChoice HealthPlan, but are not required to any may refuse to file your claims. You are then responsible for filing a claim to BlueChoice HealthPlan's office, on a form provided by or satisfactory to BlueChoice HealthPlan, within six months of the date of service. Failure to provide this information within the time required shall invalidate Coverage for the service unless it was not reasonably possible to have furnished the required information within six months. If you are legally incapacitated, failure to provide this information to BlueChoice HealthPlan within one year of the date of service shall invalidate Coverage for the service.

You may use a form provided by BlueChoice HealthPlan or an American Medical Association insurance form, which is available at most Physicians' offices. Claim forms are available on the BlueChoice HealthPlan Web site at www.BlueChoiceSC.com. Some claims may require additional information before being processed. Actual benefit payment can be determined only at the time a claim is submitted and all facts are presented in writing.

If you request claim forms from BlueChoice HealthPlan, BlueChoice HealthPlan must provide the forms within 15 days after receipt of the request. If BlueChoice HealthPlan fails to provide the forms within 15 days, you may satisfy the time requirements stated above by supplying BlueChoice HealthPlan with the following information:

1. Subscriber's name and address.
2. Patient's name, age and identification number (stated on the Identification Card).
3. The name and address of the Provider of services.
4. A diagnosis from the Physician.
5. Itemized bill that gives a CPT code or description of each charge.
6. Date service provided.
7. Charge for each service.

Claims should be mailed to:

BlueChoice HealthPlan
Post Office Box 6170
Columbia, SC 29260-6170

Questions about claims may be directed to Member Services at 786-8476 in Columbia or 1-800-868-2528 outside the Columbia area.

Non-Participating Providers can also bill you for charges in excess of the Reasonable and Customary Fee Schedule.

Benefits payable under the Contract are not assignable to a non-Participating Provider, unless determined otherwise by BlueChoice HealthPlan in its sole discretion. This means BlueChoice HealthPlan may send benefit payments to you and you will be responsible for paying the Provider.

4.03 Prescription Medication Expenses

When your Physician prescribes medication, be sure to have it filled at a Participating Network Pharmacy. Show the pharmacist your ID card so that the claim can be filled electronically for you.

You can find a listing of Participating Network Pharmacies in your Provider directory, or go to our online Provider directory at www.BlueChoiceSC.com. Not all pharmacies are part of this network.

SECTION 5
WHAT'S NOT COVERED

5.01 Exclusions

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

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

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

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

4. Treatment of an illness contracted or injury sustained while engaged in the commission or an attempt to commit an assault or a felony; treatment of an injury or illness incurred while engaged in an illegal act or occupation; treatment of an injury or illness due to voluntary participation in a riot or civil disorder.

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

6. Custodial care or respite care.

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

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

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

10. Services, supplies, or drugs for the treatment of infertility including, but not limited to, artificial insemination and in-vitro fertilization; fertility drugs; reversal of sterilization procedures; and surrogate parenting.

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

12. Any drugs, services, treatment or supplies determined by the medical staff of the Corporation, with appropriate consultation, to be Experimental, Investigational or Unproven Services. NOTE: Benefits are provided for off-label uses of pharmaceuticals that have been approved by the US FDA (but not approved for the prescribed use) provided that the drug is not contraindicated by the FDA for the off-label use prescribed, and that the drug has been proven safe, effective and accepted for the treatment of the specific medical condition for which the drug has been prescribed, as evidenced by the results of

good quality-controlled clinical studies published in at least two or more peer reviewed full length articles in respected national professional medical journals.

13. All vitamins, except prenatal vitamins; drugs not approved by the Food and Drug Administration; drugs for the treatment of non-Covered therapies, services, or conditions such as drugs prescribed for obesity or weight control, cosmetic purposes, hair growth, fertility, or sexual dysfunction.

14. Plastic or cosmetic surgical procedures or services performed to improve appearance or to correct a deformity without restoring a bodily function, unless such services are Medically Necessary and due to physical trauma, prior surgery, or congenital anomaly.

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

16. Medical supplies, services or charges for the diagnosis or treatment of dissociative disorders, sexual and gender identity disorders, personality disorders, learning disorders, developmental speech delay, communication disorders, developmental coordination disorders, mental retardation or vocational rehabilitation.

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

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

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

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

21. Group counseling or psychotherapy.

22. Any service or supply for the diagnosis or treatment of sexual dysfunction including, but not limited to, surgery, drugs, laboratory and x-ray tests, counseling, or penile implant necessary due to any medical condition or organic disease.

23. Services or supplies related to dysfunctional conditions of the muscles of mastication, malpositions or deformities of the jaw bone(s), orthognathic deformities or temporomandibular joint (TMJ) disorders including, but not limited to, surgical treatment, appliances and orthodontia.

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

    - an operation or treatment for the fitting or wearing of dentures, regardless if needed due to injury of natural teeth due to an accident;
    - orthodontic care or treatment of malocclusion;
    - operations on or treatment of or to the teeth or supporting bones and/or tissues of the teeth except for removal of malignant tumors or cysts;

- any treatment of an injury to natural teeth due to an accident not received within 6 months of the accident date;
- removal of teeth, whether impacted or not; and
- any operation, service, prosthesis, supply or treatment for the preparation for, and the insertion or removal of a dental implant.

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

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

26. Charges incurred as the result of a missed scheduled appointment and charges for the preparation, reproduction, or completion of medical records, itemized bills, or claims forms. Physician charges for virtual office visits including but not limited to telephonic, internet, electronic mail or video chat consultations.

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

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

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

30. Items that do not provide a direct medical treatment, are generally available without a physician's prescription, and may be useful to a Member in the absence of disease, including but not limited to the purchase or rental of air conditioners, home air filtration systems, motorized transportation equipment, escalators or elevators, swimming pools, waterbeds, exercise equipment, or other similar items or equipment.

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

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

33. Charges for acupuncture, hypnotism, biofeedback therapy, massage therapy and/or TENS units. Services for chronic pain management programs or any program developed by centers with multidisciplinary staffs intended to provide the interventions necessary to allow the patient to develop pain coping skills and freedom from dependence on analgesic medications.

34. Services, supplies, treatment or medication for the management of morbid obesity, obesity, weight reduction, weight control or dietary control (collectively referred to as "Obesity-related treatment") including, but not limited to, gastric bypass or stapling, intestinal bypass and related procedures or gastric restrictive procedures.

Also, the treatment or correction of complications from Obesity-related treatment are non-covered services, regardless of Medical Necessity, prescription by a physician or the passage of time from a Member's obesity-related treatment. This includes the reversal of Obesity-related treatments, and reconstructive procedures necessitated by weight loss.

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

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

37. Treatment of weak, strained or flat feet, including orthopedic shoes or other orthotic supportive devices, for services and supplies for cutting, removal or treatment of corns, calluses or nail care. This exclusion does not include corrective surgery, or treatment for metabolic or peripheral vascular disease.

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

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

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

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

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

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

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

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

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

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

48. Any service (other than substance abuse services), medical supplies, charges or losses resulting from a Member being Legally Intoxicated or under the influence of any drug or other substance, or taking some action the purpose of which is to create a euphoric state or alter consciousness unless taken on the advice of a Physician, even if the condition is not diagnosed prior to the injury. The Member, or the Member's representative, must provide any available test results showing drug/substance levels and/or blood alcohol levels upon our request of and, if the Member refuses to provide these test levels, no benefits will be provided.

5.02 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.

5.03 Method of Counting Creditable Coverage

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

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

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

SECTION 6
WHEN COVERAGE BEGINS

6.01 Eligibility

1. Every Employee within the classification(s) 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 such Employee has completed the period of continuous employment commonly referred to as the Waiting Period with the Employer. Neither an Employee nor the Employee's Dependents shall be Covered until the Employee is Actively At Work.

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

   A. meet the Employer's eligibility requirements for Dependent Coverage; and
   B. be the Subscriber's legal spouse; or
   C. be the Subscriber's natural child, adopted child, foster child, step child, or child for whom the Subscriber has legal custody or legal guardianship. The child must be less than 26 years of age (unless otherwise specified on the Master Group Application), unless the child of the Subscriber is an Incapacitated Dependent. Coverage of an Incapacitated Dependent will continue beyond the attainment of the limiting age, provided proof of such incapacity and dependency is furnished to BlueChoice HealthPlan by the Employee within 31 days of such child's attainment of that limiting age, as long as Coverage remains in force for the Employee.

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.

6.02 Election of Coverage

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

6.03 Effective Date of Coverage

Unless otherwise provided in this certificate, 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 Notice of Election is filed prior to the Effective Date and the Employee is Actively At Work.

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

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

5. For an adopted child of the Employee:

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

6.04 Special Enrollment Periods

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

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

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

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

   A. was under a COBRA continuation provision and the coverage under the provision has exhausted; or
   B. was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a result of legal separation, divorce, death, termination

of employment, or reduction in the number of hours of employment, or employer contributions toward the coverage were terminated;

C. was one of multiple health insurance plans offered by an employer and the employee elects a different plan during an open enrollment period.

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

The following apply to a Dependent Special Enrollment Period:

5.

A. If a Group Health Plan makes Coverage available for a dependent of an individual, and

B. the individual is a participant under the plan, or has met any Waiting Period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period, and

C. the person becomes a dependent of the individual through marriage, birth, or adoption or placement for adoption, then

D. the health insurance issuer offering Health Insurance Coverage in connection with the Group Health Plan shall provide for a Dependent Special Enrollment Period during which the person may be enrolled under the plan as a Dependent of the individual. In the case of the birth or adoption of a child, the spouse of the individual may be enrolled as Dependent of the individual if such spouse is otherwise eligible for Coverage.

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

A. the date dependent Coverage is made available; or

B. the date of the marriage, birth, or adoption or placement for adoption.

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

A. in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received.

B. in the case of a dependent's birth, or a dependent’s adoption or placement for adoption, within 31 days of birth, as of the date of the birth; or

C. in the case of a dependent's adoption or placement for adoption beyond 31 days from the date of birth, the date of the adoption or placement for adoption.

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

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

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

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

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

SECTION 7
WHEN COVERAGE ENDS

7.01 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 rendered after the date of termination for medical conditions arising prior to the date of termination, shall automatically terminate on the earliest of the dates specified below.

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

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

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

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

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

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

7. The date the Subscriber dies.

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

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

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

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

Under certain circumstances, Members who cease to be eligible for Coverage under the Contract may be eligible to continue Coverage under the Contract or to convert to another policy. Members should refer to the following paragraphs in this section for additional details.

7.02 Payment and Reimbursement Upon Termination

Termination of the Contract shall not affect any request for reimbursement of Eligible Expenses for Covered Services rendered prior to the effective date of termination, when such request is furnished as required in Section 4, Participating and Non-Participating Providers, of this certificate.

7.03 Extended Coverage for Incapacitated Dependent

The Coverage of an Incapacitated Dependent under this Contract will not be terminated merely by the attainment of the limiting age, but may be continued provided proof of such incapacity and dependency is furnished to BlueChoice HealthPlan by the Employee within 31 days of such child's attainment of that limiting age, as long as Coverage remains in force for the Employee. Further proof of continued incapacity and dependency may be required by BlueChoice HealthPlan, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

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

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

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

that the Dependent is receiving ongoing medical care by a Physician and is unable to perform any of the usual and customary duties or activities of a person in good health of the same age and sex.

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

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

7.05 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 to determine if he or she is eligible to continue Coverage under COBRA.

7.06 Continuation Coverage Under State Law

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

7.07 Conversion Privilege For A Former Spouse

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

SECTION 8
COORDINATION OF BENEFITS AND SUBROGATION

8.01 Purpose of COB

A person may be covered for benefits under more than one health plan. In this case, BlueChoice HealthPlan will coordinate benefits with the other plans to prevent duplicate payments and overpayments. This nationally accepted cost-containment program provides that 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 HealthPlan cannot pay until information is provided concerning how much the other coverage paid. The person must report to BlueChoice HealthPlan 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 apply:

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 are 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 healthcare 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 healthcare 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; and then
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 Point of Service product.

8.02 Right to Receive and Release Needed Information

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

8.03 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 HealthPlan 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 HealthPlan will not pay that amount again. Payment made includes the reasonable cash value of any benefit provided in the form of services.

8.04 Right of Recovery

If the amount of the payment made under this plan is more than permitted under this COB provision, BlueChoice HealthPlan 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; and/or
3. other entities.

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

8.05 Subrogation

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

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

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

SECTION 9
REVIEWS AND APPEALS

9.01 Information and Records

BlueChoice HealthPlan is entitled to obtain such authorization from the Member for medical and Hospital records from any Provider of services as is reasonably required in the administration of benefits hereunder. The Member agrees that benefits for any professional or facility Covered Services are contingent upon receipt of such information or records. BlueChoice HealthPlan shall in every case hold such records as confidential except as authorized by a Member or as required by law. BlueChoice HealthPlan shall not release confidential 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 HealthPlan to obtain any medical or financial records and documents useful to BlueChoice HealthPlan. BlueChoice HealthPlan is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim is processed. Any party submitting medical or financial reports and documents to BlueChoice HealthPlan in support of a Member's claim shall be deemed to be acting as the agent of the Member.

9.02 ERISA

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

9.03 Claims Processing

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

1. **Initial Claims**

A. **Urgent Claims**

An urgent claim is any claim for medical care or treatment where making a determination under the normal timeframes could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

If your claim is determined to be an urgent claim, a notice will be sent as soon as possible, taking into account the medical exigencies, but in no case later than 72 hours after receipt of the claim. You may be given notice orally, in which case a written notice will be provided within 3 days of the oral notice. If your urgent claim is determined to be incomplete, you will be sent a notice to this effect within 24 hours of receipt of your claim, at which point you will have 48 hours to provide additional information.

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

B. **Pre-Service Claims**

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

If your pre-service claim is improperly filed or does not follow the procedures established in this Certificate of Coverage, you will be sent notification within five days of receipt of the claim. If your pre-service claim is filed properly, a claims determination will be sent within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days from receipt of the claim. If BlueChoice HealthPlan determines that an extension is necessary due to matters beyond the control of the plan, this time may be extended another 15 days. You will be sent notice prior to the extension that indicates the circumstances requiring the extension and the date by which the plan expects to render a determination. If the extension is necessary in order to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. BlueChoice HealthPlan then will make its determination within 15 days from the date it receives your information or, if earlier, the deadline to submit your information.

C. **Post-Service Claims**

A post-service claim is a claim for services that already have been rendered, or where your benefits plan does not require prior authorization.

When you submit a post-service claim and your claim is denied, a notice will be sent within a reasonable time period, but not longer than 30 days from receipt of the claim. If BlueChoice HealthPlan determines that an extension is necessary due to matters beyond the control of the plan, this time may be extended 15 days. You will be sent notice prior to the extension that indicates the circumstances requiring the extension and the date by which the plan expects to render a determination. If the extension is necessary in order to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. BlueChoice HealthPlan then will make its determination within 15 days from the date it receives your information or, if earlier, the deadline to submit your information.

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 a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review, if you are enrolled in an ERISA plan;
- disclose any internal rule, guideline, or protocol relied upon in making the adverse determination (or state that such information is available free of charge upon request); and
- if the denial is based on medical necessity, experimental treatment or other similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

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

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.

Requests for appeals should be sent to:

BlueChoice HealthPlan
Appeals Department
Mail Code AX-325
PO Box 6170
Columbia, SC 29260-6170

You will have the opportunity to present testimony, submit written comments, documents, or other information in support of your appeal and you will have access to all documents that are relevant to your claim. If BlueChoice HealthPlan considers or presents additional evidence in connection with your appeal or uses new or additional reasons as the basis of the adverse determination, you will be notified of the new evidence or rationale in advance of the date of the appeal decision. Your appeal will be conducted by someone other than the person who made the initial decision. No deference will be afforded to the initial determination.

If your claim involves a medical judgment question, BlueChoice HealthPlan will consult with an appropriately qualified healthcare practitioner with training and experience in the field of medicine involved. If a healthcare professional was consulted for the initial determination, a different healthcare professional will be consulted on appeal. Upon request, BlueChoice HealthPlan will provide you with

the identification of any medical expert whose advice was obtained on behalf of the plan in connection with your appeal.

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

A. **Urgent Claims**

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

B. **Pre-Service Claims**

When you request a review of a pre-service claim, you will be notified of the determination within a reasonable period of time, taking into account the medical exigencies, but not longer than 30 days from the date your request is received.

C. **Post-Service Claims**

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

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

- state the specific reason(s) for the adverse determination;
- reference the specific plan provisions on which the benefit determination is based;
- state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- describe any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures;
- disclose any internal rule, guideline, or protocol relied upon in making the adverse determination (or state that such information will be provided free of charge upon request); and
- if the denial is based on medical necessity, experimental treatment, or other similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

3. **LEGAL ACTIONS**

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

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

A. De minimus;
B. Non-prejudicial;

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

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

4. EXTERNAL REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION

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

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

After all internal appeals are completed, you will be notified in writing of the right to request an external review. You should file a request for review within four months of receiving that notice. You will be required to authorize the release of any medical records that may need to be reviewed for the purpose of reaching a decision during the external review. If you need assistance during the external review process, you have the right to contact the South Carolina Department of Insurance. The Director of the South Carolina Department of Insurance or his designee may be contacted at the following address and telephone number:

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

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

A. contacting the South Carolina Department of Insurance to request the assignment of an independent review organization and forwarding records used in making the decision to the independent review organization; or
B. telling you in writing that the situation does not meet the requirements for an external review and the reasons for this decision.

The Member will be notified in writing when an independent review organization has been assigned. The Member has five business days from the date the Member receives the Corporation's response to submit additional information to the independent review organization in writing. The independent review organization must consider this additional information when conducting its review. The independent review organization will also forward this information to the Corporation within one business day of its receipt. The independent review organization will take action on the request for review within 45 days after receipt of the request.

Expedited reviews are available if your Physician certifies that you have a serious medical condition, meaning one that requires immediate medical attention to avoid serious impairment to bodily functions, serious harm to an organ or body part, or that would place your health in serious jeopardy. You also may receive an expedited review if the denial involves an Emergency Admission or Emergency care; if you have not been discharged from a facility after receiving that care; and if you will be held financially responsible. A Member can request an expedited external review at the same time as requesting an expedited internal review. For an expedited external review, the independent review organization must make its decision as fast as possible but within no more than 72 hours after it receives the request for an expedited review.

SECTION 10
GENERAL CONTRACT PROVISIONS

10.01 Conformity With Statutes

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

10.02 Workers' Compensation Not Affected

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

10.03 Relationship With Providers

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

10.04 Relationship Between Parties

The Contract constitutes a Contract solely between the Employer and BlueChoice HealthPlan of South Carolina, Inc. BlueChoice HealthPlan of South Carolina, Inc. is an independent corporation operating under a license with the Blue Cross and Blue Shield Association 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.

10.05 Coverage Exceptions

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

10.06 Policies and Procedures

BlueChoice HealthPlan 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.

10.07 Medical Loss Ratio

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

10.08 Summary of Benefits and Coverage

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

SECTION 11
COMPLIANCE WITH MEDICAL CHILD SUPPORT ORDER

11.01 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.

11.02 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:

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; and
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).

11.03 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:

   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; and
   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; and
   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.

11.04 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 <u>any</u> 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:

   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; or
   D. the date the Employer eliminates family health coverage for all Employees under all of the Employer's Group Health Plans.

SECTION 12
CONTACT US

12.01 Resolution of a Question

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

www.BlueChoiceSC.com

or by calling:

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

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

Members may 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.

12.02 Complaints and Grievances

Our goal is for Members to be completely satisfied with the benefits and services associated with their BlueChoice HealthPlan 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 email, call or write a Member Services representative (see above for addresses). If the complaint involves a representative of BlueChoice HealthPlan, the request should be addressed to the chief operating officer of BlueChoice HealthPlan of South Carolina, Inc. If a complaint is related to the quality of care received by a Member, it is considered a grievance. You should submit a description of the problem in writing to a Member Services representative.

SECTION 13
DEFINITIONS

This section defines the terms used throughout this certificate and is not intended to describe Covered and non-Covered Services. The terms defined in this section or in the following sections of 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.

Accountable Care Organization (ACO) – a group of healthcare providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.

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

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

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

Authorize or Authorization - prior approval from the Corporation for a Provider of health care services to provide certain Covered Services to a Member. In order to receive Out-of-Network benefits for inpatient Admissions, an Authorization is required. Covered Services provided must be in accordance with the Authorization in order to receive benefits under this Plan.

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

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

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

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

1. TEACCH,
2. Auditory Integration Therapy,
3. Higashi Schools/Daily Life,
4. Facilitated Communication,

5. Floor Time (DIR, Developmental Individual-difference Relationship-based model),
6. Relationship Development Intervention (RDI), Holding Therapy,
7. Movement Therapies,

8. Music Therapy, and
9. Pet Therapy.

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

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

BlueChoice HealthPlan – trade name for BlueChoice HealthPlan of South Carolina, Inc.

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

Care Coordinator – an individual within a provider organization who facilitates Care Coordination for patients.

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

Coinsurance - the percentage of expenses for a Covered Service payable by the Member. Coinsurance is based on the lesser of the negotiated rate or the Provider's charge.

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

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

Copayment - the fixed amount, if any and as indicated in the Schedule of Benefits, that is payable by the Member to the Provider each time the Member receives a Covered Service.

Coverage or Covered - the entitlement by a Member to receive benefits for Covered Services provided under the Contract, subject to the terms, conditions, limitations and exclusions of the Contract.

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

1. Covered Services must be provided when the Contract is in effect;
2. Covered Services must be provided prior to the date of termination of Coverage;
3. Covered Services must be provided only when the recipient is a Member and meets all eligibility requirements specified in the Contract; and
4. Covered Services must be Authorized when required under this Contract.

Creditable Coverage – coverage of an individual under any of the following:

1. A Group Health Plan;
2. Health Insurance coverage;
3. Medicare Part A or B;
4. Medicaid, other than coverage consisting solely of benefits under Section 1928;
5. Military, TRICARE OR CHAMPUS;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool, including the South Carolina Health Insurance Pool (SCHIP);
8. The Federal Employee Health Benefits Program;
9. A public health plan (any plan established or maintained by a State, the U.S. government, a foreign country or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage); or
10. A health benefit plan under the Peace Corps Act;
11. Short Term Health; or
12. A State Children's Health Insurance Program (S-CHIP).

Creditable Coverage does not include coverage consisting solely of those benefits excepted from the definition of Health Insurance Coverage.

Custodial Care - care provided primarily for maintenance of the patient or care designed essentially to assist the patient in meeting his or her activities of daily living. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medications that do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively. Custodial Care is not primarily provided for therapeutic value in the treatment of a sickness, injury, disease, or condition.

Deductible - the amount of Covered expenses, as indicated in the Schedule of Benefits, that the Member must incur each Benefit Period before benefits are payable for certain Covered Services.

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

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

Durable Medical Equipment - medical equipment that can withstand repeated use, is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of a sickness or injury, and is appropriate for use in the home. Such equipment must be necessary for, or be used in, the course of treatment of disease and/or disorders. Durable Medical Equipment also includes oxygen, a feeding pump, and nutritional supplements when administered through a feeding pump.

Eligibility Date - the date when all of the eligibility requirements are met by an Employee or Dependent.

Emergency Covered Services - those healthcare services and supplies necessary for the treatment of an Emergency Medical Condition, subject to the terms and conditions of this Contract.

Emergency Medical Condition (Emergency) - a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; or (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

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

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

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

Expense Incurred - the liability incurred by a Member for a service as of the date the service is rendered.

Experimental, Investigational or Unproven Services – medical, surgical, diagnostic, psychiatric, substance abuse or other healthcare technologies, supplies, treatments, procedures, drug therapies or devices that at the time provided, or sought to be provided, are determined by BlueChoice HealthPlan to be:

1. not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use or not identified in the American Hospital Formulary Service, or the United States Pharmacopoeia Drug Information or
2. subject to review and approval by any Institutional Review board for the proposed use; or
3. the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
4. not supported by at least two or more peer reviewed full length articles in respected national professional medical journals with results of good quality controlled clinical studies indicating the service is safe, effective and accepted for the treatment of the specific medical condition for which it was prescribed.

Fee Schedule - the negotiated amount to be paid by BlueChoice HealthPlan to Participating Providers for Covered Services.

Genetic Information - information about genes, gene products, and inherited characteristics that may derive from the Member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes of chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Global Payment/Total Cost of Care – a payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, hospital services and prescription drugs.

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

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

1. coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;
2. coverage issued as a supplement to liability insurance;
3. liability insurance, including general liability insurance and automobile liability insurance;
4. workers' compensation or similar insurance;
5. automobile medical payment insurance;
6. credit-only insurance;
7. coverage for on-site medical clinics;
8. other similar insurance coverage, under which benefits for medical care are secondary or incidental to other insurance benefits;
9. if offered separately:
   A. limited scope dental or vision benefits;
   B. benefits for long-term care, nursing home care, home healthcare, community-based care, or any combination of these; or
   C. other similar, limited benefits;
10. if offered as independent, non-coordinated benefits:
    A. coverage only for a specified disease or illness;
    B. hospital indemnity or other fixed indemnity insurance;
11. if offered as a separate insurance policy:
    A. Medicare supplemental health insurance;
    B. coverage supplemental to the coverage provided under military, TRICARE or CHAMPUS; and
    C. similar supplemental coverage under a Group Health Plan.

Health Services - healthcare services and supplies Covered under the Contract.

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

1. health status;
2. medical condition, including both physical and mental illnesses;
3. claims experience;
4. receipt of healthcare;
5. medical history;
6. Genetic Information;
7. evidence of insurability, including conditions arising out of domestic violence; or
8. disability.

Hospital - a short-term, acute care (1) general Hospital, (2) children's Hospital, (3) eye, ear, nose and throat Hospital, (4) maternity Hospital, or (5) any other type of short-term acute care Hospital licensed by the state in which it operates, that for compensation from its patients and on an inpatient basis, is engaged primarily in providing diagnostic and therapeutic facilities for the medical or surgical diagnosis and treatment of injured or

sick persons, by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which provides continuous 24 hour-a-day services by licensed, registered, graduate nurses physically present and on duty. A Hospital may participate in a teaching program. This means that a Member may be seen or treated by a medical student, intern, or resident participating in such a teaching program.

Identification Card (ID Card) - the card most recently issued by BlueChoice HealthPlan showing the Member's identification number.

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

Incapacitated Dependent - a child who is: (1) incapable of self-support because of mental retardation, mental illness or physical incapacity which began before the child reached the limiting age; and (2) dependent upon the Employee for at least 51% of support and maintenance and who has fulfilled the requirements of Section 6.01, Eligibility, paragraph 2.C. of this certificate.

Late Enrollee - an eligible Employee or Dependent who enrolls under this plan other than during the first period in which the individual is eligible to enroll under the plan if the initial enrollment period is a period of at least 30 days; or a Special Enrollment Period.

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

Local Service Area - the geographic area served by BlueChoice HealthPlan and approved by the appropriate regulatory body in the state of South Carolina.

Long-Term Acute Care Facility - a facility that meets the definition of a Hospital providing care to patients whose average length of stay is greater than 25 consecutive days as set out in the American Hospital Association Guide to the Health Care Field, published annually.

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

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

Medically Necessary or Medical Necessity - health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are

1. in accordance with generally accepted standards of medical practice; and
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. not primarily for the convenience of the patient, physician, or other health care provider; and

4. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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

Member's Effective Date - the date (beginning at 12:01 a.m.) on which the Member is enrolled and eligible for benefits under the terms of this Contract. See Section 6.03, Effective Date of Coverage, for further details.

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

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

Negotiated Arrangement a.k.a., Negotiated National Account Arrangement – an agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

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

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

Out-of-Network Coverage - benefits for non-Emergency, self-referred Covered Health Services or supplies obtained from non-Participating Providers.

Out-of-Pocket Maximum - the maximum amount incurred during the Benefit Period for which benefits are not payable by BlueChoice HealthPlan. The Out-of-Pocket Maximum is made up of Coinsurance, Copayment and Deductible amounts payable by the Member, as indicated in the Schedule of Benefits.

Participating - the status of a Provider of Covered Services who has entered into a written agreement with BlueChoice HealthPlan to provide Covered Services to Members and to join BlueChoice HealthPlan’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 considered to be Participating Providers in the context of this Certificate of Coverage.

Patient-Centered Medical Home (PCMH) – a model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.

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

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

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

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

Primary Care Physician - a Participating Physician whose practice predominantly includes family practice, internal medicine, pediatrics, gynecology, or obstetrics/gynecology; or a nurse-practitioner.

Provider - any person licensed in, or legally engaged in the practice of, or performing duties associated with, any of the following: medicine; surgery; dentistry; pharmacy; optometry; osteopathy; podiatry; chiropractic; radiology; nursing; physiotherapy; pathology; anesthesiology; laboratory analysis; rendering assistance to a Physician; psychiatry; psychology; physical therapy; Substance Abuse treatment; home healthcare; an Alternate Facility; Hospital; Long-Term Acute Care Facility; Skilled Nursing Facility; or Rehabilitation Hospital. A Provider may participate in a teaching program. This means that a Member may be seen or treated by a medical student, intern, or resident participating in such a teaching program.

Provider Incentive – an additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

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

Reasonable and Customary Fee Schedule - the allowance established by BlueChoice HealthPlan for Covered Services performed by non-Participating Providers. In the event the Reasonable and Customary Fee Schedule does not apply for a specific service or supply, the allowance will be the actual charge as submitted or the Fee Schedule for Participating Providers, whichever is less.

Rehabilitation Hospital - a licensed facility that is engaged primarily in providing rehabilitation care to patients on an inpatient basis. Rehabilitation care consists of the combined use of medical, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.

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

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

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

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

Shared Savings – a payment mechanism in which the provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

Skilled Nursing Facility - an institution that is recognized under Medicare as a Skilled Nursing Facility, primarily engaged in providing skilled nursing care, rehabilitation services and related care. A Skilled Nursing Facility is not a facility or institution which is primarily a place for rest or residence.

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

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

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

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

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

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

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

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

Urgent Care Services - Covered Services required as the result of a sudden illness or injury and in order to prevent significant deterioration of a Member's health.

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

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

® Registered marks of the Blue Cross and Blue Shield Association

July 1, 2018

Dear Valued Customer:

The Medicare Modernization Act requires employers to compare their health plan's prescription drug benefits to the standard Medicare prescription drug benefit, and provide notice of the results of the comparison to each Medicare-eligible member of their health plan who has prescription drug coverage. This notice is required in order to help the members decide whether to enroll in a Medicare Prescription Drug Plan or continue with any prescription drug coverage provided by the employer's health plan.

An employer's pharmacy benefits are considered "creditable" if the benefits are at least as generous as the Medicare Part D benefits. BlueChoice HealthPlan's actuarial department has evaluated your pharmacy benefits using criteria outlined by the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicare program. Our evaluation has determined that your coverage is at least as generous as the Medicare Part D benefits and therefore considered creditable.

Federal law requires that this information be issued to employees during the initial Medicare prescription drug open enrollment period. As a courtesy, we are enclosing a sample notice that you may use to inform employees that your prescription drug coverage is comparable to the standard Medicare prescription drug benefit and therefore considered creditable. This sample is based on the model notice provided by CMS. You may use this sample notice or create your own notice to your employees.

Note: As an employer, you must notify CMS that your coverage is considered creditable.

Details regarding the Medicare Modernization Act and options related to Medicare Part D may be found at https://www.cms.gov/CreditableCoverage/

If you have any questions, please call BlueChoice HealthPlan Member Services at 1-800-868-2528, Monday through Friday from 8:30 a.m. to 8:30 p.m.

Sincerely,

BlueChoice HealthPlan

Encl.

Important Notice from BlueChoice HealthPlan About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Rogers Townsend and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **BlueChoice HealthPlan has determined that the prescription drug coverage offered by Rogers Townsend is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Rogers Townsend coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Rogers Townsend service coverage, be aware that you and your dependents may not be able to get this coverage back.

The details of your current coverage through Rogers Townsend are as follows:

BlueChoice HealthPlan Group Number:	00408 / 286787575-78
Effective Date:	July 1, 2018

Prescription Medication:	Deductible

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Rogers Townsend and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact your Human Resources department for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through BlueChoice HealthPlan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender:
Contact--Position/Office:
Address:
Phone Number:

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190 . (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険
についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。
(Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)