Blue Option
Outline of Coverage

Major Medical Expense Coverage
Policy Form No. Blue Option (Rev. 1/25)

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

If you need information about this health coverage – Call BlueChoice HealthPlan of South Carolina, Inc.'s (BlueChoice) Member Services Department. From Columbia, dial 786-8476, from anywhere else in the state, dial 855-816-7636 toll free. You may also send your inquiries through the web site at www.BlueOptionSC.com.

Blue Option is an Exclusive Provider Organization (EPO) plan. An EPO is a managed care plan where services are covered only if you go to Providers in the Blue Option Network, except in an Emergency. Benefits are provided in-Network only.

No benefits are provided for services received out-of-Network unless the services are (1) due to an Emergency Medical Condition and provided at an Urgent Care Center, Hospital or Freestanding Emergency Room, (2) Medically Necessary air ambulance services; or (3) except where the Provider satisfies advance patient notice and consent requirements, services provided by an out-of-Network Provider at certain in-Network facilities, or specified out-of-Network post-Stabilization services resulting from an Emergency Medical Condition.

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

Read Your Contract Carefully
Blue Option is a non-grandfathered health plan. This Outline of Coverage provides a very brief description of the important features of Blue Option. This is not the insurance policy and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of you and BlueChoice HealthPlan of South Carolina, Inc. Please READ YOUR POLICY CAREFULLY. It accompanies this Outline of Coverage. It gives special instructions on how to get authorization and how to handle an emergency.

Major Medical Expense Coverage
Policies of this category are designed to provide coverage to persons insured for major Hospital, medical and surgical expenses incurred because of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, in-Hospital medical services and out-of-Hospital care subject to any Deductibles, Copayments or other limitations that may be set forth in the policy.

Individual Coverage
You do not need prior Authorization from BlueChoice or from any other person (including your Primary Care Physician) to obtain access to a pediatrician for children or gynecological care (from a Provider who specializes in gynecology) for women from a health care professional in our Network. The health care professional, however, may be required to comply with certain procedures, including obtaining prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of Participating health care professionals who specialize in gynecology, contact BlueChoice at 786-8476 in Columbia or 855-816-7636, toll free from anywhere else. You can also visit our website at www.BlueOptionSC.com/Findcare for the most current list of Participating Physicians.

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

- All Inpatient Admissions, except for Emergency Admissions
  - For emergency admissions, you or someone acting on your behalf must notify BlueChoice no later than 24 hours after the admission or the next working day, whichever is later.
- Continued Inpatient Admissions
- Outpatient facility admissions, except for Emergency Admissions
  - For Emergency Admissions, you or someone acting on your behalf must notify BlueChoice no later than 24 hours after the Admission or the next working day, whichever is later.
- All Inpatient, Outpatient/office psychological testing, intensive Outpatient and/or partial hospitalization programs, repetitive transcranial magnetic stimulation (rTMS) and electroconvulsive therapy and certain prescription drugs for Behavioral Health disorders
- Dental Services to Sound Natural Teeth related to Accidental Injury after initial visit
- Genetic counseling
- Habilitation services
- Home health services
- Hospice services.
- Covered transplants, which must be obtained at Blue Distinction® Centers for Transplants.
- Durable Medical Equipment (DME) that has a purchase price or rental cost of $500 or more (Any supplies used with DME must be Authorized every 90 days)
- Virtual colonoscopies, subject to medical management guidelines
- Procedures and/or treatment of varicose veins
- Services, supplies, or charges for a covered Multi-disciplinary Pain Management Program, regardless of the state of location of the Provider
- Prescription drugs as listed in the Prescription Drug List
- Cardiac rehabilitation
- Pulmonary rehabilitation
- Dialysis
- Radiation oncology
- Injectable/infusible chemotherapy
- Treatment of hemophilia
- Advanced radiology
- Nuclear cardiology
- Musculoskeletal care
- Home infusion therapy
- Home occupational therapy
- Home physical therapy
- Home speech therapy
- Biofeedback

Benefit Description

All Copayments, Deductible and Coinsurance will apply toward the Maximum Out-of-pocket. Copayments do not apply toward your Deductible. Covered Services will be provided at 100 percent once you reach your Out-of-pocket Maximum. The Out-of-pocket Maximum does not include Premiums, Balance-billed charges or health care the policy doesn't cover.

Benefits are subject to all terms, conditions, limitations, and exclusions outlined the policy.

Bronze Plan Options

Plan Benefits	Bronze 6500	Bronze 8000	Bronze 7200 HD
Deductible:			
Individual	$6,500	$8,000	$7,200
Family	$13,000	$16,000	$14,500
Coinsurance	30%	50%	0%
Out-of-Pocket Maximum:			
Individual	$9,200	$9,200	$7,200
Family	$18,400	$18,400	$14,400
Copayments:			Copayments not applicable to this plan. All Covered Services are subject to the Deductible
PCP	$60	$65	
Blue CareOnDemand	$30	$33	
Specialist	$110	$100	
Urgent Care	$75	$75	
Free-Standing Ambulatory Surgery Center	$200	$200	
Emergency Room*	$300	Subject to Deductible	
Inpatient Admissions*	$300		
Outpatient Professional Services* for:			
Surgery	$300		
Prescription Drugs – Retail:			
Tier 1	$35	$35	0%
Tier 2	30%	50%	0%
Tier 3	30%	50%	0%
Tier 4	30%	50%	0%
Tier 5	30%	50%	0%
Tier 6	30%	50%	0%
Prescription Drugs – Mail Order:			
Tier 1	$70	$70	0%
Tier 2	30%	50%	0%
Tier 3	30%	50%	0%
Tier 4	30%	50%	0%
Tier 5	30%	50%	0%
Tier 6	30%	50%	0%

* These services are also subject to the Deductible and Coinsurance in addition to the Copayment.

Silver Plan Options

Plan Benefits	Silver 2250	Silver 3200	Silver 4500	Silver 5225 HD
Deductible: Individual Family	 $2,250 $4,500	 $3,200 $6,400	 $4,500 $9,000	 $5,225 $10,450
Coinsurance	50%	50%	50%	0%
Out-of-Pocket Maximum: Individual Family	 $7,500 $15,000	 $8,100 $16,200	 $8,900 $17,800	 $5,225 $10,450
Copayments:				Copayments not applicable to this plan. All Covered Services are subject to the Deductible
PCP	$45	$45	$35	
Blue CareOnDemand	$23	$23	$18	
Specialist	$85	$90	$80	
Urgent Care	$50	$50	$50	
Free-Standing Ambulatory Surgery Center	$200	$200	$200	
Emergency Room*	$400	$400	$300	
Inpatient Admissions*	$400			
Skilled Nursing Facility/Residential Treatment Center*	Subject to Deductible	Subject to Deductible	Subject to Deductible	
Outpatient Professional Services* for: Surgery	 $100	 $100	 $100	
Prescription Drugs – Retail:				
Tier 1	$25	$25	$25	0%
Tier 2	50%	$50	$50	0%
Tier 3	50%	$90	$90	0%
Tier 4	50%	$300	$300	0%
Tier 5	50%	$300	$300	0%
Tier 6	50%	$300	$300	0%
Prescription Drugs – Mail Order:				
Tier 1	$50	$50	$50	0%
Tier 2	50%	$100	$100	0%
Tier 3	50%	$180	$180	0%
Tier 4	50%	$600	$600	0%
Tier 5	50%	$600	$600	0%
Tier 6	50%	$600	$600	0%

* These services are also subject to the Deductible and Coinsurance in addition to the Copayment.

Silver Plan Options

Plan Benefits	Silver 5550	Silver 6250	Silver 7350	Silver 8600
Deductible:				
Individual	$5,550	$6,250	$7,350	$8,600
Family	$11,100	$12,500	$14,700	$17,200
Coinsurance	35%	25%	50%	0%
Out-of-Pocket Maximum:				
Individual	$7,400	$8,600	$9,200	$8,600
Family	$14,800	$17,200	$18,400	$17,200
Copayments:				
PCP	$35	$35	$35	$0
Blue CareOnDemand	$18	$18	$18	$0
Specialist	$85	$70	$80	$60
Urgent Care	$50	$50	$50	$50
Free-Standing Ambulatory Surgery Center	$200	$200	$200	$200
Emergency Room*	$500	$300		$500
Inpatient Admissions*	Subject to Deductible	Subject to Deductible		
Skilled Nursing Facility/Residential Treatment Center*	$500		Subject to Deductible	Subject to Deductible
Outpatient Professional Services* for: Surgery	Subject to Deductible	$100		
Prescription Drugs – Retail:				
Tier 1	$35	$28	$35	$35
Tier 2	35%	$40	$60	$60
Tier 3	35%	$90	$80	0%
Tier 4	35%	$300	$300	0%
Tier 5	35%	$300	$300	0%
Tier 6	35%	$300	$300	0%
Prescription Drugs – Mail Order:				
Tier 1	$70	$56	$70	$70
Tier 2	35%	$80	$120	$120
Tier 3	35%	$180	$160	0%
Tier 4	35%	$600	$600	0%
Tier 5	35%	$600	$600	0%
Tier 6	35%	$600	$600	0%

* These services are also subject to the Deductible and Coinsurance in addition to the Copayment.

Gold Plan Option

Plan Benefits	Gold 1500	Gold 3200 HD
Deductible:		
Individual	$1,500	$3,300
Family	$3,000	$6,600
Coinsurance	35%	0%
Out-of-Pocket Maximum:		
Individual	$5,000	$3,300
Family	$10,000	$6,600
Copayments:		Copayments not applicable to this plan. All Covered Services are subject to the Deductible
PCP	$15	
Blue CareOnDemand℠	$8	
Specialist	$50	
Urgent Care	$50	
Free-Standing Ambulatory Surgery Center	$200	
Emergency Room*	$250	
Prescription Drugs – Retail:		
Tier 1	$20	0%
Tier 2	$20	0%
Tier 3	$35	0%
Tier 4	$70	0%
Tier 5	$250	0%
Tier 6	$250	0%
Prescription Drugs – Mail Order:		
Tier 1	$40	0%
Tier 2	$70	0%
Tier 3	$140	0%
Tier 4	$500	0%
Tier 5	$500	0%
Tier 6	$500	0%

* These services are also subject to the Deductible and Coinsurance in addition to the Copayment.

Catastrophic Plan Options

Plan Benefits	Catastrophic
Deductible: Individual Family	 $9,200 $18,400
Coinsurance **Out-of-Pocket Maximum**: Individual Family	0% $9,200 $18,400
Copayments: PCP /Blue CareOnDemand Copayments for PCP/ Blue CareOnDemand are limited to the first three visits. Then it is subject to Deductible.	 $25
Prescription Drugs – Retail: Tier 1 Tier 2 Tier 3 Tier 4 Tier 5 Tier 6 **Prescription Drugs – Mail Order:** Tier 1 Tier 2 Tier 3 Tier 4 Tier 5 Tier 6	 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0%

COVERED SERVICES

Professional Services (performed outside the office setting) Hospital services [1] Behavioral Health Laboratory Outpatient X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)
Maternity care – Routine Maternity Physician Services
Mandated Preventive Care & Routine Care (includes mammogram and colonoscopy)
Facility Services / Inpatient Hospital[1] Inpatient hospital (includes maternity care and Behavioral Health) Skilled Nursing Facility/Residential Treatment Centers/Long-Term Acute Care Facility
Facility Services / Outpatient Hospital[1] Outpatient services (includes Ambulatory Surgical Center and maternity care) Freestanding Ambulatory Surgical Center (centers not affiliated with Hospital)[2] Outpatient Surgery Physician/Surgical services Behavioral Health Emergency Room (includes Professional Services) in-Network and out-of-Network – In order for Emergency Room care to be covered, care must be for an Emergency Medical Condition.
Prescription Medication Tier 1 Tier 2 Tier 3 Tier 4 Tier 5 Tier 6
Other Services Ambulance (special rules apply to air ambulance) Dental services due to accidental injury Durable Medical Equipment (DME) Habilitative Services Home Health Hospice Initial Prosthetic Devices Rehabilitative Occupational, Physical & Speech Therapy

BENEFITS	MEMBERS PAYS
Pediatric Vision Care – EyeMed Providers Only (Refer to Provider Directory) Pediatric Vision Care is provided under an agreement between EyeMed and BlueChoice. EyeMed is an independent company that provides vision services on behalf of BlueChoice.	
Exam with Dilation as necessary	$15 Copayment for all plans
Retinal Imaging	Up to $39
Standard Contact Lens Fit and Follow-up	Up to $40
Premium Contact Lens Fit and Follow-up	10% off Retail Price
Frames: Any available frame at provider location	$25 Copayment for Provider designated frames for all plans
Standard Plastic Lenses (single vision, bifocal, trifocal, lenticular, and standard progressive)	$0 Copayment for all plans
Lens Options:	
UV Treatment	$15
Tint (Solid and Gradient)	$15
Standard Plastic Scratch Coating	$15
Standard Polycarbonate	$0 Copayment
Standard Anti-Reflective Coating	$45
Polarized	20% off Retail Price
Oversized	20% off Retail Price
Other Add-Ons	20% off Retail Price
Contact Lens (Includes materials only)	
Conventional, disposable, and medically necessary	$25 copayment for Provider designated contact lenses
Additional Pairs Benefit	Members also receive a 40% discount off complete pair eyeglasses purchases and a 15% discount off conventional contact lenses once the contact lens allowance has been used
Laser Vision Correction:	
Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price
Exams, frames lenses and contact lenses are limited to one per Member per Benefit Period.	

Plan Maximums	Plan Maximum Per Member
Durable Medical Equipment	Up to purchase price
Home Health	60 visits per Benefit Period
Hospice	6 months per episode
Rehabilitative – Occupational Therapy, Physical Therapy,	30 combined visits per Benefit Period
Habilitative Services – Occupational Therapy, Physical Therapy,	30 combined visits per Benefit Period
Prosthetic Devices	1 item per episode
Skilled Nursing Facility/Residential Treatment Center	60 days per Benefit Period
Chiropractic services	5 visits per Benefit Period
Benefit Period	Calendar Year

The following services are not Essential Health Benefits and Do Not apply to your Deductible or Maximum Out-of-pocket.

BENEFITS	MEMBERS PAYS
Adult Routine Vision Care – EyeMed Providers Only (Refer to Provider Directory) Adult Routine Vision Care is provided under an agreement between EyeMed and BlueChoice. EyeMed is an independent company that provides vision services on behalf of BlueChoice.	
Exam with Dilation as necessary	$0 Copayment for all plans
Retinal Imaging	Up to $39
Frames, Lens & Options Package: (Any frame, lens and lens options available at Provider location)	$150 Allowance for frame, lens and lens options; 20% off balance over $150
Contact Lenses: Conventional Disposable Medically Necessary	 $0 Copayment; $150 allowance; 15% balance over $150 $0 Copayment; $150 allowance; plus balance over $150 $0 Copayment
Additional Pairs Benefit	Members receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once contact allowance has been used
Laser Vision Correction: Lasik or PRK from U.S. Laser Network	 15% off Retail Price or 5% off promotional price
Exams, frames lenses and contact lenses are limited to one per Member per Benefit Period.	
Preventive Dental Care (any licensed dentist) One dental exam every six months, a maximum of two per Benefit Period One dental cleaning every six months, a maximum of two per Benefit Period	 Balance over $50 Balance over $50

BENEFITS	MEMBERS PAYS
My Life Consult^{SM} ◆ Individual & Family Counseling (visits 1-3)	$0
◆ Life Management Services (3 visits)	$0
Benefits are provided under an agreement between First Sun EAP and BlueChoice. Because First Sun EAP is a separate company from BlueChoice, First Sun EAP is responsible for all services it provides. For services, please call First Sun EAP at 800-968-8143. First Sun EAP staff is available 24 hours a day, seven days a week.	

[1] Includes post-stabilization services resulting from an Emergency, and services provided by an out-of-Network Provider at certain in-Network facilities, subject to a limited exception where the Provider satisfies advance patient notice and consent requirements.

[2] Includes services provided by an out-of-Network Provider at an in-Network Freestanding Ambulatory Surgical Center, subject to a limited exception where the Provider satisfies advance patient notice and consent requirements.

A Summary of Benefits and Coverage, also known as an SBC, is available to you online by using this link http://www.blueoptionsc.com/SBC . You may request a printed copy by calling the Member Service phone number on the back of your ID card. **Please Note:** The format and content of an SBC is controlled by federal agencies and some details may appear inconsistent with information in the policy or your Schedule of Benefits. If information is inconsistent, the policy is the controlling document.

Benefits are available when Covered Services are Medically Necessary.

Benefits are provided In-network only. No benefits are provided for services received Out-of-network, unless the services are (1) due to an Emergency Medical Condition and provided at an Urgent Care Center, Hospital or free-standing emergency room, (2) Medically Necessary air ambulance services, or (3) when the Provider satisfies advance patient notice and consent requirements, services provided by an out-of-Network Provider at certain in-Network facilities, or specified out-of-Network post-Stabilization services resulting from an Emergency Medical Condition.

For a complete description of Covered Services, please refer to the What Is Covered section of the policy.

Special Out-of-Network Rules

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

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

If you need assistance because one of these things has occurred, please contact us using the information on the back of your ID card or as shown in the section How to Contact Us of the policy.

The BlueCard® Program. As a Blue Cross and Blue Shield licensee, BlueChoice participates in a national program called the BlueCard Program. This program benefits you when you receive Covered Services while traveling outside our service area, which is the state of South Carolina. The BlueCard is your BlueChoice identification card. Your card tells Participating BlueCard Hospitals and/or Physicians which independent Blue Cross and Blue Shield licensee is yours.

If you need care outside of South Carolina, follow these easy steps:

- Always carry your current BlueChoice ID card for easy reference and access to service. Need your Member ID card? Log in to My Health Toolkit®, where your digital ID card is always available. You can view, print or share your Member ID card any time you need it. Download the mobile app and you'll have your digital ID card right in your pocket. You can get the app through the Apple or Google app stores. Just search for My Health Toolkit.
- To find names and addresses of nearby doctors and hospitals, visit the BlueCard Doctor and Hospital Finder website at www.BCBS.com or call BlueCard Access at 800-810-BLUE.
- When you arrive at the Participating Provider, simply present your BlueChoice ID card.

After you receive care, you should not have to complete any claim forms. Nor should you have to pay for medical services other than your usual out-of-pocket expenses (non-Covered Services, Deductible, Copayment, and Coinsurance).

OUT-OF-AREA SERVICES

Overview – BlueChoice has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area BlueChoice serves, 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 ("non-Participating Providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

Under the BlueCard Program, when you receive covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for doing what we agreed to in the contract. However the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

When you receive covered healthcare services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare 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 healthcare 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 Members 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. Non-Participating Providers Outside Our/Licensee Name Service Area (Optional)

1. **Member Liability Calculation**

   When covered healthcare services are provided outside of our service area by non-Participating Providers, the amount you pay for such services will normally be based on either the Host Blue's non-Participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the non-Participating Provider bills and the payment we will make for the covered healthcare services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. **Exceptions**

   In certain situations, we may use other payment methods, such as billed charges for Covered Services, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount we will pay for services provided by non-Participating Providers. In these situations, you may be liable for the difference between the amount that the non-Participating Provider bills and the payment we will make for the covered healthcare services as set forth in this paragraph.

D. BCBS Global™ Core Program

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 BCBS Global Core Program when accessing Covered Services. BCBS Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although BCBS 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 are, 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 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, will arrange a Physician appointment or hospitalization, if necessary.

- **Inpatient Services**

  In most cases, if you contact the BCBS Global Core Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the Hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services.

  You must contact BlueChoice to obtain 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 BCBS 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 BCBS Global Core claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BlueChoice, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

Emergency Services:
Use of the Emergency Room is only for persons who are experiencing an Emergency Medical Condition, as defined in the policy. We will review requests for benefits after an Emergency Room visit to determine meets the definition of an Emergency Medical Condition. Requests for services that do not meet this standard will be denied as not covered.

Benefits are available to treat an Emergency Medical Condition only when provided at a Hospital or free-standing emergency room or at an Urgent Care Center, and only (1) for as long as your condition continues to be considered an Emergency, or (2) for certain post-Stabilization services described below. If you receive such care related to an Emergency Medical Condition, the charges for Emergency Services are paid as follows:

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

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

If you are admitted to a Hospital due to an Emergency Medical Condition, you or someone acting on your behalf must contact BlueChoice within 24 hours or the next working day, whichever is later at 1-800-950-5387. If the Admission occurs outside the local service area or at an out-of-Network Provider, you may be required to transfer to a Hospital within the local service area once your condition has Stabilized to receive benefits. If an Admission occurs within 24 hours after an Emergency visit because of the Emergency Medical Condition, the Emergency Copayment, if any, will be waived and the applicable Copayment for Admission will be assessed.

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

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

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

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

Exclusions and Limitations of the Policy

No benefits are provided for the following, unless otherwise specified in the Schedule of Benefits. Notwithstanding any provision of the policy to the contrary, if the policy generally provides benefits for any type of injury, then in no event shall an exclusion or limitation of benefits be applied to deny coverage for such injury if the injury results from an act of domestic violence or a medical condition, including both physical and Behavioral Health condition, even if the medical condition is not diagnosed before the injury.

Excluded Services

Except as specifically provided in the policy, even if Medically Necessary, no benefits will be provided for:

1. Services for which no charge is normally made in the absence of insurance.

2. Services, supplies or prescription drugs for which you are entitled to benefits under Medicare or other governmental programs (except Medicaid).

3. Injuries or diseases paid by workers' compensation or settlement of a workers' compensation claim.

4. Treatment provided in a government Hospital that you are not legally responsible for.

5. Illness contracted or injury sustained as the result of war or act of war, whether declared or undeclared; participation in a riot or insurrection; or service in the armed forces or an auxiliary unit.

6. Treatment, services, or supplies received as a result of suicide, attempted suicide or intentionally self-inflicted injuries unless it results from a medical (physical or mental) condition, even if the condition is not diagnosed prior to the injury.

7. Any plastic or reconstructive Surgery done mainly to improve the appearance or shape of any body part and for which no improvement in physiological or body function is reasonably expected, also known as cosmetic Surgery. Cosmetic Surgery includes but is not limited to Surgery for saggy or extra skin (regardless of reason); any augmentation, reduction, reshaping or injection procedures of any part of the body; rhinoplasty, abdominoplasty, liposuction, and other associated types of Surgery; and any procedures using an implant that doesn't alter physiologic or body function or isn't incidental to a covered surgical procedure. Cosmetic Surgery does not include reconstructive Surgery incidental to or following Surgery resulting from trauma, infection, or other diseases of the involved part. Complications arising from cosmetic Surgery are also not covered.

8. Eyeglasses, contact lenses (except after cataract Surgery), except as shown in the Covered Services section, and hearing aids and exams for the prescription or fitting of them. Any Hospital or Physician charges related to refractive care such as radial keratotomy (Surgery to correct nearsightedness), keratomileusis (laser eye Surgery or Lasik), lamellar keratoplasty (corneal grafting) or any such procedures that are designed to alter the refractive properties of the cornea.

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

10. Services, care or supplies used to detect and correct, by manual or mechanical means, structural imbalance, distortion, or subluxation in your body for the purpose of removing nerve interference and its effects when this interference is the result of or related to distortion, misalignment, or subluxation of, or in, the spinal column after the 5 visit limit has been reached.

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

12. Physician services directly related to the care, filling, removal, or replacement of teeth; the removal of impacted teeth; and the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. This includes but is not limited to apicoectomy (dental root resection), root canal treatment, alveolectomy (Surgery for fitting dentures) and treatment of gum disease. Exception is made, as shown in the Covered Services section, for dental treatment to Sound Natural Teeth for up to six months after an accident and for Medically Necessary cleft lip and palate services.

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

Other Services The Policy Does Not Cover

14. Services, supplies or prescription drugs received from a non-Network Provider, unless the services are (1) due to an Emergency Medical Condition and received in a Hospital or free-standing Emergency Room or Urgent Care center, (2) Medically Necessary air ambulance services, or (3) except where the Provider satisfies advance patient notice and consent requirements as described herein, services provided by an out-of-Network Provider at certain in-Network facilities, or specified out-of-Network post-Stabilization services resulting from an Emergency Medical Condition.

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

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

17. Any Covered Service provided more than applicable limits described in this policy or the Schedule of Benefits.

18. Services and supplies you received before you had coverage under this policy or after you no longer have this coverage except as described in Extension of Benefits under Eligibility in the When Your Coverage Ends section of the policy.

19. Any charges by the Department of Veterans Affairs (VA) for a service-related disability.

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

21. All Admissions to Hospitals or free-standing Rehabilitation Facilities for physical rehabilitation when the services are not done at a designated Provider and/or you do not get the required prior Authorization.

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

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

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

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

Relating to other conditions or services:
- Dorsal rhizotomy (cutting spinal nerve roots) in the treatment of spasticity (increased tone or tension in a muscle such as a leg).

24. The following transplants are not Covered Services:
    a. Uses of allogeneic bone marrow transplantation (between two related or unrelated people) or syngeneic bone marrow transplantation (from one identical twin to the other) along with other forms of stem cell transplant (with or without high doses of chemotherapy or radiation) in cases in which less than four of the six complex antigens match; cases in which mixed leukocyte culture is reactive; and AIDS and HIV infection;
    b. Adrenal tissue to brain transplants;
    c. Procedures that involve the transplantation of fetal tissues into a living recipient;
    d. Mechanical or animal organ transplants.

25. Services and supplies related to transplants involving mechanical or animal organs, human organ and/or tissue transplant procedures when you do not get the required prior Authorization and it is not done at a Designated Provider, or unless specifically listed in the Covered Services section of the policy.

26. Reduction mammoplasty for macrosastia unless your Body Mass Index (BMI) is less than or equal to 30 and meets Medical Necessity in accordance with BlueChoice's medical guidelines.

27. Any treatment or Surgery for obesity (even if morbid obesity is present), weight reduction or weight control, such as gastric by-pass, insertion of stomach (gastric) banding, intestinal bypass, wiring mouth shut, liposuction or complications from it, unless and to the extent such services may be covered under, and you receive such services while participating in, an approved program listed in the Covered Services section of the policy. This includes any reversal or reconstructive procedures from such treatments. Treatment for obesity may be covered if a Member participates in the My Health Novel program.

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

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

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

31. Biofeedback, unless Authorized.

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

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

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

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

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

37. Services, supplies or charges for wellness or alternative treatment programs, acupuncture, massage therapy, hypnotism, and transcutaneous electrical nerve stimulation (TENS) unit therapy or any kind of pain management, unless and to the extent such services may be covered under, and you receive these services while participating in, an approved program listed under the Covered Services section of the policy.

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

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

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

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

42. Physician charges for virtual office visits including but not limited to telephonic, internet, electronic mail or video chat consultations unless listed in the Schedule of Benefits.

43. Telemonitoring, except as shown in the Covered Services section of the policy.

44. Telehealth services which are initiated by either a Member or Provider (including but not limited to a medical doctor) in which the method of web-based or video communication is not secure, does not occur in real-time and/or are not provided by Network Providers who have been credentialed as eligible telehealth Providers.

45. Telemedicine services which do not comply with all the requirements specified in the Covered Services section of the policy.

46. Any service or supply related to dysfunctional conditions of the chewing muscles, wrong position or deformities of the jaw bone(s), orthognathic deformities, or temporomandibular joint syndrome (headache, facial pain and jaw tenderness caused by jaw problems usually known as TMJ).

47. Luxury or convenience items whether a Physician recommends or prescribes them.

48. All travel expenses, including those related to a transplant such as, but not limited to immunizations prior to travel, transportation, lodging and repatriation, unless specifically included in the Covered Services sections of the policy.

49. Routine, non-Emergency ambulance transportation, including, but not limited to travel to a facility for scheduled medical or surgical treatments, such as dialysis or cancer treatment or transfer to a sub-acute place of care such as a Skilled Nursing Facility.

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

51. Durable Medical Equipment when you do not get the required prior Authorization and any charges more than the purchase price.

52. Equipment or supplies that have non-therapeutic uses and equipment and supplies that are available over the counter such as but not limited to air conditioners, air filters, whirlpool baths, spas, humidifiers or dehumidifiers, wigs, fitness supplies, vacuum cleaners or common first-aid supplies.

53. Manual or motorized wheelchairs or power operated scooters unless Medically Necessary for mobility in the patient's home.

54. Benefits will be denied for procedures, services, or pharmaceuticals when you do not get the required prior Authorization.

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

56. Any services or supplies you or a member of your immediate family provides, including the dispensing of drugs. A member of your family means spouse, parent, grandparent, brother, sister, aunt, uncle, child or in-law.

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

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

59. Services, supplies or treatment for varicose veins and or venous incompetence, including but not limited to endovenous ablation, vein stripping or sclerosing solutions injection, and to the extent otherwise provided in the policy or Schedule of Benefits.

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

61. Prescription and/or specialty drugs:
    - That are used for or related to non-Covered Services or conditions, such as but not limited to weight control, obesity, erectile dysfunction, cosmetic purposes (such as Tretinoin or Retin-A, Kybella for chin fat), hair growth and hair removal. We also exclude all vitamins, except for prenatal vitamins due to pregnancy or otherwise covered as preventive care.
    - That are used for infertility.
    - That are more than the number of days' supply allowed as shown in the Covered Services of the policy.
    - That are refills more than of the number specified on your Physician's prescription order.
    - That are for more than the recommended daily dosage defined by BlueChoice unless prior Authorization is sought and received.
    - When administered or dispensed in a Physician's office, Skilled Nursing Facility, Residential Treatment Center, Hospital, or any other place that is not licensed to dispense prescription drugs.
    - That are available over the counter or when there is an over-the-counter drug equivalent that contain the same active ingredients as the prescription version including any over-the-counter supplies, devices, or supplements.
    - When not consistent with the diagnosis and treatment of an illness, injury, or condition or that is excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate, and appropriate care.
    - That require Authorization and the Authorization is not received.
    - That are classified as self-administered drugs when obtained, purchased and/or administered at a doctor's office or in an Outpatient setting.
    - That requires step therapy when a step therapy program is not followed.
    - That are received out-of-Network, unless due to an Emergency Medical Condition that is treated at an Urgent Care Center or Hospital Emergency Room.
    - That are not on the Prescription Drug List
    - That are medications or drugs for which some or all the Cost Sharing is paid by a drug manufacturer in any form of direct support (cash, reimbursement, coupon, voucher, debit card, etc.) that reduces or eliminates immediate out-of-pocket costs for a specific prescription brand-name drug. Although the drug remains a covered prescription drug, Cost Sharing amounts provided by the drug manufacturer will not be counted toward the Member's annual limitation on Cost Sharing.
    - That are new to the market and under clinical review by BlueChoice 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 whether the drug should be covered.
    - That are prescription drugs and pharmaceuticals that could be covered under both the medical and prescription drug portion of this coverage. In that case, coverage is provided under the prescription drug benefit only.

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

Extension of Benefits after Termination of Coverage

If BlueChoice does not renew or terminates your contract and you are in the hospital or continuously and totally disabled when your coverage under this contract ends, benefits will be provided while you remain continuously and totally disabled for the same cause. Benefits are subject to the terms, conditions, exclusions and limitations of the contract. This coverage will continue until you (1) have full coverage for the disabling condition under a health plan with similar benefits and that plan makes reasonable provisions for continuity of care for the disabling condition; (2) are no longer totally disabled; (3) you use up all of your benefits, or (4) until the end of a period of 365 consecutive days, whichever occurs first. Benefits will be paid only for charges related to treatment of the disabling condition.

The term “Totally Disabled” means you are receiving ongoing medical care by a physician and can perform none of the usual and customary duties or activities of a person in good health of the same age. A child who is Totally Disabled is receiving ongoing medical care by a Physician and unable to perform the normal activities of a child in good health of the same age and sex. A Physician’s statement of disability will be required.

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

Renewability Provision

Guaranteed Renewable Except For Stated Reasons: BlueChoice shall renew or continue the policy at the person’s option. We may nonrenew or discontinue this policy for any of these reasons:

- Failure to pay Premiums or if we have not received timely Premium payments
- Fraud or material misrepresentation
- Discontinuance of Blue Option by BlueChoice for everyone who had it
- Discontinuance of individual health insurance in the state of South Carolina by BlueChoice.
- The person no longer resides, works or lives in South Carolina.

However, we will not decline to renew the policy simply because of a Health Status-Related Factor or because a Member’s health changes. At the time of renewal, we may modify the policy for everyone who has it as long as the modification is consistent with federal and state law and is effective on a uniform basis.

Individual Transfer Right

Any person purchasing an individual accident, health or accident and health insurance policy, will have the right to transfer to any individual policy currently being issued e by BlueChoice That is most like, but not greater than, the terminated coverage.

Premiums

If you previously had coverage with BlueChoice or its affiliated companies, your policy was canceled due to nonpayment of Premiums and you re-apply for coverage within 12 months, you must pay all past due Premiums before you can activate new coverage or begin using benefits.

Premiums are due and payable in full on or before the monthly due date. The benefits described are available as long as the required Premium is paid. If you enroll in our automatic draft for your Premiums, and later decide to cancel the automatic draft, it must be cancelled at least three business days prior to the draft. We will not accept payment of your Premiums from any health care Provider, health agency, health entity, public or private institution or any other person or entity which does not have an insurable interest.

Other than Premiums for the initial month, a grace period will be granted for the payment of Premiums. During this grace period the policy will continue in force. The Policyholder will be liable for all Premiums due and unpaid for the period the policy continues in force. If Premiums are not received by the end of the grace period, the policy will automatically terminate without further notice to the Policyholder. The termination will be effective back to the Premium due date. Any claims paid after the last Premium paid date does not extend the coverage.

BlueChoice bases Premiums on coverage selected, age, residence, tobacco use and regulatory fees and taxes required by the Affordable Care Act. Premiums may only be changed at the beginning of your Benefit Period. At least 31 days prior to your new Benefit Period, you will receive notice of your new Premium.

If the Member's age, residence or tobacco use has been misstated and if the amount of the Premiums is based on these factors, an adjustment in Premiums, coverage, or both, will be made based on the Member's true age, residence or tobacco use. No misstatement of age, residence or tobacco use will continue insurance that has been otherwise validly terminated or terminate coverage otherwise validly in force.

When BlueChoice pays a claim, BlueChoice may deduct any Premium due from the claim payment.

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