2023 EVIDENCE OF COVERAGE

Select Health of South Carolina, Inc.

Individual Member Health Maintenance Organization (HMO) Policy

This is your contract with Select Health of South Carolina, Inc. Please read it carefully. This policy's effective date is January 1, 2023, unless a different effective date is confirmed when you apply and enroll.

Select Health of South Carolina, Inc. is a Health Maintenance Organization (HMO). This Evidence of Coverage provides coverage for Essential Health Benefits according to the provisions described in this policy and as shown in the associated Schedule of Benefits. Please refer to the policy details that follow for more information on covered health services and important limitations. Your policy also describes preventive services covered with no cost-sharing.

Important cancellation information: Please read the Eligibility and Termination provision on page 22 of this policy.

Insured's Name: _____

Policy Number: _____

Thank you for choosing to enroll for coverage with Select Health of South Carolina, Inc.! When this **Evidence of Coverage** document says "we," "us," "our," "health plan," or "plan," it means Select Health of South Carolina, Inc. It also means the health plan that Select Health operates, known as First Choice Next. When it says "you," "your," or "yours," it means the **subscriber** and any eligible **dependents**.

This document is your contract with us. Sometimes we call it a "policy." It outlines what health care services and prescription drugs your insurance covers. It lists the amount you will need to pay toward their costs during the period of your policy. It explains how to get coverage for **health care services** and prescription drugs you need. **Please read this document carefully. Keep it in a safe place.** If you are not satisfied, return the policy to our agent or us within 10 days after you receive it. However, if we provide you with this **policy** directly, you can return the policy within 30 days from the date you receive the **policy**. All **premiums** paid will be refunded, less claims paid and the policy will be considered null and void from the effective date.

We use a **network** of **participating providers** to provide services for you. We will not cover services you receive from **out-of-network providers** except in limited cases described elsewhere in this document. Participating **physicians**, **hospitals,** and other **health care providers** are independent contractors. They are neither our agents nor employees. The availability of any **provider** cannot be guaranteed. Our **provider network** is also subject to change.

Benefits, **copayments**, **deductible,** or **coinsurance** may change on renewal of this **policy**. The health plan's **formulary**, pharmacy **network**, and/or **provider network** may change at any time. **Members** will receive advance notice of these changes when applicable.

Renewal

This **policy** will renew on January 1 of each year, at your option, if you pay the needed **premium**. The **policy** will not renew if it is ended earlier by you or by us, as described elsewhere in this document. This health plan is a regulated insurance product. Its **policy** forms, rates, **premium**s, **cost-sharing** arrangements, and other materials are filed each year for approval by the South Carolina Department of Insurance. As such, your **premium**s may

increase when you renew. However, we will write to you about any increases at least 60 days before the increase goes into effect. We will write to you only after the South Carolina Department of Insurance has approved the increase.

This document is also available in other formats, like Braille, large print, or audio. Questions? We can help you learn how to get alternate formats of this document and how to use your health plan. Just call our Member Services team at 1-833-983-7272, 8 a.m. – 8 p.m., 5 days a week.

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Definitions of Important Words Used in This Document

- **Accident** or **accidental injury** — Injury or injuries for which you have **benefits**. This means **accidental** bodily injury sustained by the insured person that is the direct cause of the loss. It is not caused by disease or bodily infirmity or any other cause. It also occurs while the insurance is in force.

- **Adverse Benefit Determination** — A determination by a **health benefit plan** or its designee that an admission, availability of care, continued stay, or other health care service that is a **covered benefit** has been reviewed. Based on the information provided, the service:
  - Does not meet the **health benefit plan's** requirements for **medical necessity**, suitability, health care setting, level of care, or effectiveness; or
  - Is experimental or investigational and involves a life-threatening or **seriously disabling** condition. The requested service or payment for the service is, therefore, denied, reduced, or ended.
  - Will not be paid for by the **health benefit plan** because the member is not eligible to participate in a plan; or
  - Coverage has been rescinded (whether or not the rescission has an adverse effect on any benefit at that time).
- **Allowed amount** — The amount we pay a **provider** for a **covered health service** provided to a **member.** It is the lesser of the **provider's** charge or our maximum payment amount. If you need to pay a **coinsurance,** it is a percentage of the **allowed amount.**
- **Appeal** — A request to reconsider a determination not to certify an admission, procedure, extension of stay or other health care service.
- **Approved clinical trials** — A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:
  - Federally funded trials.—The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    - The National Institutes of Health.
    - The Centers for Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare & Medicaid Services.
    - Cooperative group or center of any of the entities described above or the

Department of Defense or the Department of Veterans Affairs.

- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- Any of the following if the conditions for departments are met:
  - The Department of Veterans Affairs.
  - The Department of Defense.
  - The Department of Energy.

  Conditions for Departments: The conditions described below, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines:
  - To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and
  - Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

o The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

o The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

- **Authorized representative** means:
  - o A person to whom a **covered person** has given express written consent to represent the **covered person** in an **appeal** or external review;
  - o A person authorized by law to give consent on behalf of a **covered person**; or
  - o A family **member** of the **covered person** or the **covered person's** treating **health care professional** when the **covered person** is unable to give consent.

- **Autism spectrum disorder (ASD)** — As defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the most recent edition of the International Statistical Classification of Diseases and Related Health Problems.
- **Behavioral health** — The diagnosis and treatment of a mental or behavioral disease, disorder, or condition listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), as revised, or any other diagnostic coding system. This applies whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin.

- **Benefit period** — One calendar year or **plan year**, applied per the terms of the **member's** plan. However, when a **member** is initially enrolled, the **benefit period** will be the date of enrollment through the end of the then-current calendar year.
- **Benefits** — Your right to payment for **covered health services** under this **policy**.
- **Brand name drug** — A prescription drug made and sold by the pharmaceutical company that first researched and developed the drug. **Brand name drugs** have the same active-ingredient formula as the generic version of the drug. However, **generic drugs** are made and sold by other drug makers. These drugs are generally not available until after the patent on the **brand name drug** has expired.
- **Center of Excellence** — A **Center of Excellence** is a team, shared facility, or entity that provides leadership, best practices, research, support, and/or training in a focus area. First Choice Next evaluates transplant programs throughout the U.S. First Choice Next only includes transplant programs that meet our strict Center of Excellence criteria in our **network**. We annually re-evaluate programs to ensure the **network** maintains its care standards.
- **Clinical peer** — A health care professional who holds an unrestricted license in a state of the United States, in the same or similar specialty. A **clinical peer** routinely provides **health care services** subject to **utilization review.**
- **Clinical Review Criteria** — The written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by an **insurer** to decide the necessity and suitability of **health care services** and supplies. They are based on sound clinical evidence that is periodically evaluated to ensure ongoing efficacy.
- **Coinsurance** — A percentage of the **allowed amount** you need to pay for **covered health services** and prescription drugs**.** A **copayment** is not a **coinsurance**. **Copayment** is defined elsewhere in this policy.
- **Complaint** — The formal name for making a **complaint** is filing a **grievance**. The **complaint** process is only used for certain types of problems. These include problems related to quality of care, waiting times, and the customer service you receive. (See "**Grievance**," in this list of definitions). **Complaints** do not involve coverage or payment disputes. Those types of disputes are addressed through the **appeals** process. (See "**Appeal**" in this list of definitions.)
- **Complication of pregnancy** — Medical conditions whose diagnoses are separate from pregnancy. They may be caused or made more serious by pregnancy. They may also put the mother's life or health in jeopardy or make a live birth less viable. Examples include:
  - Abruption of placenta
  - Acute nephritis

- **Emergency** cesarean section, if provided in the course of treatment for a **complication of pregnancy**
- Kidney infection
- Placenta previa
- Poor fetal growth
- Preeclampsia or eclampsia

- **Continuation of care** — The provision of **in-network** level benefits for services rendered by certain **out-of-network providers** for a definite period of time in order to ensure continuity of care for **covered persons** with a **serious medical condition**.
- **Copayment (or copay)** — A specific dollar amount you may need to pay as your share of the **allowed amount** for **covered health services** or prescription drugs you get. A **copayment** is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug. A **copayment** is not a **coinsurance**. **Coinsurance** is defined elsewhere in this policy.
- **Cost-sharing** — Amounts that a **covered person** must pay when services or drugs are received. **Cost-sharing** includes any combination of these types of payments:
  - Any **coinsurance** amount, a percentage of the total amount paid for a service or drug that a health plan needs when a specific service or drug is received.
  - Any **deductible** amount a health plan may impose before services or drugs are covered.
  - Any fixed **copayment** amount that a health plan needs when a specific service or drug is received.
- **Covered benefits** — **Health care services** to which a **covered person** is entitled under the terms of a health benefit plan.
- **Covered health service** — **Health care services** payable under this **Evidence of Coverage**. They must be **medically necessary** and ordered or performed by a **provider** who is legally authorized or licensed and suitably credentialed to order or perform the service. **Covered health services** include things such as a medical service or supply, doctor's visit, **hospital** visit, or a prescription drug. For prescription drugs, **covered health services** mean drugs or supplies to treat medical conditions, such as disposable needles and syringes when given with insulin.
- **Covered person, member,** or **you** — an insured, policyholder, **subscriber**, enrollee, or other person entitled to covered benefits under a **health benefit plan**.
- **Deductible** — The amount you must pay for **covered health services** or prescription drugs each year before your **health benefit plan** begins to pay.
- **Department** — The South Carolina Department of Insurance.
- **Department of Health and Human Services** — The United States Department of

Health and Human Services (HHS), is a cabinet-level executive branch department of the U.S. federal government created to protect the health of all Americans and providing essential human services and overseeing the **Exchange.**

- **Dependent** — The **subscriber**'s spouse, domestic partner, or child who resides within the United States. "Child" includes a biological child, an adopted child, or a child placed for adoption or foster care who is younger than 18 years of age on the date of the adoption or **placement for adoption** or foster care.
- **Disenroll** or **disenrollment** — The process of ending your membership in our health plan. **Disenrollment** may be voluntary (your own choice) or involuntary (not your own choice).
- **Durable medical equipment (DME)** — Certain medical equipment and supplies ordered by your **provider** for medical reasons. Examples include:
  - Crutches
  - Diabetes supplies
  - Hospital beds ordered by a **provider** for use in the home
  - IV infusion pumps
  - Nebulizers
  - Oxygen equipment
  - Powered mattress systems
  - Speech-generating devices
  - Walkers
  - Wheelchairs
- **Effective date** — The date a **member** becomes covered under this **policy** for covered services.
- **Emergency medical care** — Health care services given in a **hospital emergency facility** to evaluate and treat an **emergency medical condition**.
- **Emergency medical condition** or **emergency** — When you, or any other prudent layperson with an average knowledge of health and medicine, reasonably think you have acute symptoms of enough severity (including severe pain) such that the absence of immediate medical attention could mean:
  - Placing your health (or, for a pregnant person, the health of the person or their unborn child) in serious jeopardy
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part

For a pregnant person having contractions, this includes if there is inadequate time to safely transfer the person to another **hospital** before delivery. It also includes if that transfer may pose a threat to the health or safety of the person or unborn child.

- **Emergency medical provider** — **Hospitals** licensed by the South Carolina Department of Health and Environmental Control, hospital-based services, **physicians** licensed by the State Board of Medical Examiners, and oral surgeons and dentists licensed by the State Board of Dentistry who provide **emergency medical care**.

- **Emergency services** — Health care items and services given or needed to screen for or treat an **emergency medical condition** until the condition is stabilized. It includes prehospital care and ancillary services routinely available to the emergency room.
- **Enrollment date** — The date of enrollment, or if earlier, the first day of the waiting period for the enrollment
- **Evidence of Coverage (EOC) and coverage information** — This document, your enrollment form, and any other attachments, **Schedule of Benefits, riders**, or other optional coverage selected, that explain your coverage. It explains your rights, what we must do, and what you must do as a **member** of our health plan.
- **Exchange/Marketplace** — Federally Facilitated Marketplace (FFM) is an organized marketplace for **health plans** operated by the U.S. Department of Health and Human Services (HHS).
- **Experimental** or **investigational** — Services include a treatment, procedure, equipment, drug, drug usage, medical device, or supply that meets one or more of the following criteria as determined by First Choice Next:
    - A drug or device that cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and has not been granted such approval on the date the service is provided.
    - A service subject to oversight by an Institutional Review Board.
    - No reliable evidence demonstrates that the service is effective in clinical diagnosis, evaluation, management, or treatment of the condition.
    - The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety, or efficacy.
    - Evaluation of reliable evidence indicates that more research is needed before the service can be classified as equally or more effective than conventional therapies.

Note: Reliable evidence includes, but is not limited to, reports and articles published in authoritative peer-reviewed medical and scientific literature. It also includes reviews and coverage recommendations for clinical effectiveness published by First Choice Next.

- **Facility** — An institution giving **health care services** or a health care setting including, but not limited to, **hospitals** and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, imaging centers, and rehabilitation and other therapeutic health settings.
- **Final internal adverse determination (Final Determination)** — An **Adverse Benefit Determination** that has been upheld by us and completes our internal **appeal** process.
- **First Choice Next Telemedicine —** The preferred vendor who we have contracted with to provide **telemedicine services** to our **members**. Our preferred vendor contracts with **providers** to render **telemedicine services** to our **members**.
- **Formulary/formulary drugs** — A list of medications we cover. Products on the **formulary** generally cost less than products that are not on the **formulary**.
- **Foster child** — A minor over whom a guardian has been appointed by the clerk of superior court of any county in South Carolina. This can also be a minor whom a court of competent jurisdiction has ordered a guardian the primary or sole custody.
- **Generic drug** — A recognized drug approved by the Food and Drug Administration (FDA) as having the same active ingredients as a **brand name drug**. Generally, a **generic drug** works the same as a **brand name drug** and costs less.
- **Grievance** — A **complaint** submitted by a **covered person**.
    - An **insurer's** decisions, policies, or actions related to availability, delivery, or quality of **health care services**.
    - A **complaint** submitted by a **covered person** about a decision rendered only because the **health benefit plan** has a **benefits** exclusion for the **health care services** in question is not a **grievance** if the exclusion of the service requested is clearly stated in the **Evidence of Coverage**.
    - Claims payment of handling or reimbursement for services.
    - The contractual relationship between a **covered person** and an **insurer.**
- **Habilitative services** — **Health care services** that help you keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational, speech, and language therapy, and other services for people with disabilities in inpatient or outpatient settings.

- **Health benefit plan/health insurance coverage** — A **policy**, contract, or certificate issued by a **health plan** that provides benefits for **medical care** given directly, through insurance or reimbursement, or otherwise. It includes 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:
  - Coverage only for accident or disability income insurance or any combination of accident and disability income insurance
  - Coverage issued as a supplement to liability insurance
  - Liability insurance, including general liability insurance and automobile liability insurance
  - Workers' compensation or similar insurance
  - Automobile medical payment insurance
  - Credit-only insurance
  - Coverage for on-site medical clinics
  - Other similar insurance coverage specified in regulations under which benefits for **medical care** are secondary or incidental to other insurance benefits
- **Health care professional/health care provider/provider** — A **physician**, dentist, facility, or other person properly licensed, where needed, to furnish **health care services**.
- **Health care services** — Services provided for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.
- **Health plan/health insurance issuer/issuer** — An entity that provides **health insurance coverage** in this state. It is also an insurance company, a health maintenance organization, and any other entity providing **health insurance coverage** that is licensed to engage in the business of insurance in this state and subject to state insurance regulation.
- **Home health aide** — A person who provides services that do not need the skills of a licensed **nurse** or therapist. Examples include help with personal care (e.g., bathing, using the toilet, dressing, or prescribed exercising). **Home health aides** do not have a nursing license or provide therapy.
- **Home health care** — **Health care services** given to the **member** in the home for treatment of an illness or injury by an organization licensed and approved by the state to provide these services.
- **Hospice** — A program for **members** who have six months or less to live that addresses the physical, psychological, social, and spiritual needs of the **member** and

their immediate family.

- **Hospital** — A short-term, acute-care **facility** that:
  - Is licensed and operated according to the law; and
  - Primarily and continuously engaged in providing or operating, either on its premises or in prearranged facilities for the **hospital** and under the supervision of a staff of duly licensed **physicians**, medical, diagnostic, and major surgical facilities for the **medical care** and treatment of sick or injured persons on an in-patient basis for which a charge is made; and
  - Gives 24-hour nursing service by or under the supervision of registered graduate professional **nurses** (RNs).

  The term "**hospital**" does not include the following types of facilities:
  - Convalescent homes, convalescent, rest, or nursing facilities; or
  - Facilities mainly affording custodial, educational, or rehabilitory care; or
  - Facilities for older people or people with drug or alcohol addictions; or
  - Any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces. An exception is for services rendered where a legal liability exists for charges made to the individual for such services.
- **Independent review organization** — An entity that conducts independent external reviews of **Adverse Benefit Determinations** and **Final Determinations**.
- **Inpatient rehabilitation facility** — A **facility** that provides inpatient rehabilitation health services, as authorized by law.
- **Insurer** — Includes a corporation, fraternal organization, burial association, other association, partnership, society order, individual, or aggregation of individuals engaging and proposing or attempting to engage as principals in any kind of insurance or surety business. This includes the exchanging of reciprocal or interinsurance contracts between individuals, partnerships, and corporations.
- **Life-threatening condition or disease** — A condition or disease that, according to the current diagnosis by the **covered person's** treating **physician**, has a high chance of causing the **covered person's** death within three years.
- **Managed care plan** — A plan operated by a managed care organization that provides for the financing and delivery of health care and treatment services to individuals enrolled in the plan through contracting with selected specific providers that conform to explicit selection standards, or both.
- **Medical and scientific evidence** means:

- Peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized needs for scientific manuscripts. The journals must also submit most of their published articles for review by experts who are not part of the editorial staff;
- Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meets the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline and Medlars database Health Services Technology Assessment Research;
- Medical journals recognized by the Secretary of Health and Human Services, under Section 1861 (t)(2) of the federal Social Security Act;
- These standard reference compendia: the American Hospital Formulary Service--Drug Information; the American Medical Association Drug Evaluation; the American Dental Association Accepted Dental Therapeutics; and the United States Pharmacopoeia-Drug Information;
- Findings, studies, or research done by or under the auspices of federal government agencies and nationally recognized federal research institutes. These include the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health to evaluate the medical value of health services.

- **Medical care** means the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid to affect any structure or function of the body. Medical care includes amounts paid for rides mainly for and essential to **medical care** and insurance covering **medical care**.
- **Medically necessary** or **medical necessity** — The **covered health services** or supplies that are:
  - Given for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease. They are not for experimental, investigational, or cosmetic uses, except as allowed under South Carolina law.
  - Needed for and suitable to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms
  - Within generally accepted standards of **medical care** in the community
  - Not only for the convenience of the insured, the insured's family, or the **provider**

  For **medically necessary** services, nothing in this subsection precludes an **insurer**

from comparing the cost-effectiveness of alternative services or supplies when determining which services or supplies will be covered.

- **Member** (**member** of our health plan, or "**health plan member**") — A person who is eligible to receive **covered health services** after their enrollment has been confirmed and any needed premium has been paid. M**embers** include the subscriber and any **dependents**.
- **Network** or **in-network** — **Health care professionals**, medical groups, **hospitals,** and other health care facilities, and **providers** who have agreed to give **covered health services** to our **members**. They also have agreed to accept our payment and any **cost-sharing** the member pays as full payment.
- **Network** or **in-network pharmacy** — A pharmacy that has an agreement with our **health benefit plan** to provide prescription drugs and other items to our members. In most cases, your prescriptions are covered only if they are filled at one of our **network pharmacies**.
- **Network** or **in-network provider** or **network/in-network facility** — **Providers** who have an agreement with our health plan to provide covered services to our **members** and to accept our payment and any **member** cost-share as a full payment. Our health plan pays **network providers** based on the agreements we have with them. **Network providers** may also be called health plan providers.
- **Network plan health** — Insurance coverage of a health insurance **issuer** under which the financing and delivery of **medical care**, including items and services paid for as **medical care**, are given, in whole or in part, through a defined set of providers under contract with the **issuer**.
- **Nurse** — The title of **nurse** is restricted to a type of **nurse**, such as registered graduate professional **nurse** (RN), a licensed practical **nurse** (LPN), or a licensed vocational **nurse** (LVN).
- **Out-of-network pharmacy** — A pharmacy that does not have an agreement with our health plan to provide covered prescriptions or other items to our **members**. Under this **Evidence of Coverage**, most drugs you get from **out-of-network pharmacies** are not covered by our health plan unless certain conditions apply.
- **Out-of-network provider** or **out-of-network facility** — A **provider** or **facility** that does not have an agreement with us to coordinate or provide covered services to **members** of our health plan. They have also not agreed to accept our payment and any **member** cost-share as a full payment. **Out-of-network providers** are not employed, owned, or operated by our health plan.
- **Out-of-pocket costs** — See the definition for **cost-sharing** above. A **member's cost-sharing** need to pay for a portion of services or drugs received or any **deductible** amount is also called the **member's** out-of-pocket cost requirement.

- **Out-of-pocket maximum** amount — The most you pay out-of-pocket during the calendar year for **in-network covered health services**. It includes **deductibles** and any **cost-sharing** amounts you have paid. Amounts you pay for your **premiums** do not count toward the **out-of-pocket maximum** amount.
- **Pap test** — An examination of the tissues of the cervix of the uterus to detect cancer when performed on the recommendation of a medical doctor. This test may be made once a year or more often if recommended by a medical doctor.
- **Partial hospitalization** — Services received from a freestanding or **hospital**-based program that provides services at least 20 hours per week and continuous treatment for at least three hours, but no more than 12 hours per 24 hours.
- **Participating provider** — A **provider** who has an agreement with an **insurer,** or with an **insurer's** contractor or subcontractor, to provide **health care services** to **covered persons**. In return, the provider receives direct or indirect payment from the **insurer**. This payment does not include **coinsurance**, **copayments**, or **deductibles**. This **provider** also agrees to accept the payment and any **member cost-sharing** as a full payment.
- **Physician** — A person duly licensed (other than an intern, resident, or house physician) as a medical doctor, dentist, oral surgeon, podiatrist, osteopath, chiropractor, optometrist, ophthalmologist, physician assistant or licensed doctoral psychologist legally entitled to practice within the scope of their license. A physician normally bills for their services.
- **Placement for adoption** or **being placed for adoption** — The assumption and retention by a person of a legal obligation for total or partial support of a child with intention to adopt the child. The child's placement with a person ends when such legal obligations end.
- **Plan year** — This is typically a calendar year. However, if your initial **effective date** is other than January 1, your initial **plan year** will be less than 12 months. It will then start on the **effective date** and run through December 31 of the same year.
- **Policy** — The document that describes the agreements between the **health benefit plan** and the **member**. Your **policy** includes this document, the **Schedule of Benefits**, your application, and any amendments or **riders**. Sometimes your **policy** is called a contract.
- **Premium** — The periodic payment to First Choice Next or another health care plan for health and/or prescription drug coverage.
- **Primary care provider (PCP)** — The doctor or other **provider** you see first for most health problems. This provider can be a **physician** in family medicine, general medicine, internal medicine, or pediatric medicine. They can also be an advanced practice **nurse**, certified **nurse** practitioner, or **physician's** assistant. They make sure

you get the care you need for your best health. They may also talk with other **health care providers** about your care and refer you to them.

- **Prior authorization** — Approval in advance to get certain services or drugs. These drugs that may or may not be in our **formulary**. Some in-network medical services are covered only if your **in-network provider** gets **prior authorization** from your **health benefit plan**.
- **Prosthetics and orthotics** — Medical devices ordered by your **health care provider**. Covered items include, but are not limited to:
  - Arm, back, and neck braces
  - Artificial eyes
  - Artificial limbs
  - Devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy
  - Prostheses following a mastectomy
- **Provider** — A general term we use for doctors, other **health care professionals**, **hospitals**, and health care facilities licensed or certified under state laws or the laws of another state to provide **health care services**.
- **Qualified Health Plan** — a **health insurance plan** that is certified by the Health Insurance Marketplace, provides essential health benefits (EHBs), follows established limits on cost sharing, and meets other requirements outlined within the application process.
- **Quantity limits** — A tool to limit the use of selected drugs for quality, safety, or utilization reasons. Drugs may be limited by the amount we cover per prescription or for a defined period of time.
- **Rescission of coverage** — A cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose. A cancellation or discontinuance of coverage is not a rescission if -
  - The cancellation or discontinuance of coverage has only a prospective effect;
  - The cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage;
  - The cancellation or discontinuance of coverage is initiated by the individual (or by the individual's authorized representative) and the sponsor, employer, plan, or issuer does not, directly or indirectly, take action to influence the individual's

decision to cancel or discontinue coverage retroactively or otherwise take any adverse action or retaliate against, interfere with, coerce, intimidate, or threaten the individual; or

- The cancellation or discontinuance of coverage is initiated by the **Exchange**.

- **Rehabilitation services** — These services include chiropractic, physical, speech, language, and occupational therapy. Services are given on an inpatient or outpatient basis and may be subject to limits as described in the **Schedule of Benefits**.
- **Rider** — An amendment to this **Evidence of Coverage** that may modify the covered **benefits**.
- **Routine patient care costs for approved clinical trials** — All items or **covered health services** that are otherwise generally available to a **covered person** that are provided in a **clinical trials** except the following:
  - The **investigational** items or service itself.
  - Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patients.
  - Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.
- **Schedule of Benefits** — A document that identifies the **member,** applicable **copayments**, **coinsurance**, **deductibles**, **out-of-pocket maximum amount**, and benefit limits for **covered health services**. If we issue a new **Schedule of Benefits**, it will replace any prior **Schedule of Benefits** on the effective date of the new **Schedule of Benefits**. A **Schedule of Benefits**, together with the **Evidence of Coverage**, riders, and other documents that amend the **Evidence of Coverage** make up your benefit plan policy.
- **Serious medical condition** — A health condition or illness, that requires medical attention, and where failure to provide the current course of treatment through the current provider would place the person's health in serious jeopardy, and includes cancer, acute myocardial infarction, and pregnancy. Such attestation by the treating **physician** must be made upon the request of the patient and in a written form approved by the Department of Insurance or prescribed through regulation, order, or bulletin.
- **Seriously disabling** — A health condition or illness that involves a serious impairment to bodily functions or serious dysfunction of a bodily organ or part.
- **Service area** — The geographic area in South Carolina as described by state law where an HMO enrolls persons who either work in the **service area**, reside in the **service area**, or work and reside in the **service area.** Visit our website to see our

coverage map of counties within our **service area**: https://www.firstchoicenext.com/view-plans/coverage-area.aspx. You may also call Member Services at 1-833-983-7272, 8 a.m. – 8 p.m., 5 days a week, to learn more.

- **Sexual dysfunction** — Any of a group of sexual disorders that cause inhibition either of sexual desire or of the psychophysiological changes that are usually part of sexual response. Included are female sexual arousal disorder, male erectile disorder, and hypoactive sexual desire disorder.
- **Skilled nursing facility (SNF)** — A licensed institution, other than a hospital, that has a contract with First Choice Next to provide skilled nursing **facility** care. The **facility** must:
  - Be operated pursuant to law;
  - Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;
  - Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed **physician**;
  - Provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional **nurse** (RN); and
  - Maintain a daily medical record of each patient.

  The term **skilled nursing facility** does not include:
  - Any home, **facility** or part thereof used primarily for rest;
  - A home or **facility** for the aged or for the care of substance use disorders; or
  - A home or **facility** primarily used for the care and treatment of mental diseases, or disorders, or custodial or educational care.
- **Skilled nursing facility (SNF) care** — Skilled nursing care and **rehabilitation services** provided continuously and daily in a **skilled nursing facility**. Examples of SNF care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.
- **Special enrollment period** — An opportunity to enroll in a health plan outside of the annual open enrollment period based on specific qualifying events, such as birth, adoption, divorce, or marriage.
- **Stabilize** — To provide **medical care** suitable to prevent a material deterioration of

the person's condition, within reasonable medical chance, per the Health Care Financing Administration (HCFA) interpretative guidelines, policies, and regulations for responsibilities of **hospitals** in **emergency** cases. These are as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. § 1395dd. They include **medically necessary** services and supplies to maintain stabilization until the person is transferred.

- **Step therapy** — A pharmacy management tool that requires you to first try another drug to treat your medical condition before we will cover the drug your **provider** may have prescribed.
- **Subscriber** — The **covered person** who is properly enrolled under this **policy** and on whose behalf this **policy** is issued. It does not include **dependents**.
- **Telemedicine services** — Includes evaluation, management, and consultation services for **behavioral health** and nonemergency medical issues with a **provider** via an interactive audio or video telecommunications system.
- **Urgent care services** — Services to treat a nonemergency, unforeseen medical illness, injury, or condition that needs immediate **medical care**. **Urgent care services** may be furnished by **network providers** or **out-of-network providers** when you can't reach an **in-network provider.**
- **Utilization Review** — A system for reviewing the necessary, suitable, and efficient allocation of health care resources and services given or proposed to be given to a patient or a group of patients. We use a set of formal techniques to monitor the use of or evaluate the clinical necessity, suitability, efficacy or efficiency of **health care services**, procedures, **providers**, or facilities. These techniques may include:
  - Ambulatory review - **Utilization review** of outpatient services.
  - Case management - A coordinated set of activities for individual patient management of serious, complicated, protracted, or other health conditions.
  - Certification - A decision by an **insurer** or its designated **Utilization Review Organization (URO)** that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, satisfies the **insurer's** requirements for **medically necessary** services and supplies, suitability, health care setting, level of care, and effectiveness.
  - Concurrent review - **Utilization review** during a patient's **hospital** stay or treatment.
  - Discharge planning - The formal process for deciding, before discharge from a provider **facility**, the coordination and management of the care that a patient receives after discharge from a provider **facility**.

- Prospective review - **Utilization review** before an admission or a course of treatment, including any needed prior authorization or precertification.
- **Retrospective review** - **Utilization review** of medically necessary services and supplies after services have been given to a patient. It includes the review of claims for **emergency services** to find whether the prudent layperson standard has been met per South Carolina law.
  - Retrospective review does not include a review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.
- Second opinion - A clinical evaluation by a **provider** other than the **provider** originally recommending a service. This is to assess the medical necessity and suitability of the proposed service.

- **Utilization Review Organization (URO)** — An entity that conducts **utilization review** under a **managed care plan.** A URO is not an **insurer** performing **utilization review** for its own **health benefit plan**.

Eligibility and Termination

To be eligible for coverage as a **member** in our health plan, you must:

- Reside in our **service area**.
- Not be enrolled in Medicare or any other insurance policy, on your **effective date** of coverage with us. If we know of your enrollment in Medicare or any other policy, we will not issue a **policy** to you. This provision does not apply to state medical assistance programs such as Medicaid.

Eligible dependents

The following persons may also be eligible to enroll as **dependents** under this plan:

- Your spouse or domestic partner, as recognized under the applicable marriage or civil union laws of South Carolina, who lives within the **service area.**
    - In the case of death of the subscriber, the spouse if covered under this **policy** will have the right to continue coverage previously given by the **policy** and exercise rights previously vested.
- Your natural or legally adopted child. We will not deny enrollment of a child on the **subscriber's** health plan for any of the following reasons:
    - The child was born out of wedlock.
    - The child is not claimed as a **dependent** on the parent's federal income tax return.
    - The child does not reside with the parent or in our **service area**.
- Stepchildren.
- Children awarded coverage through an administrative or court order.
- **Foster children**.

When they reach the limiting age, nonhandicapped **dependent children** are entitled to receive, without evidence of insurability, an individual **policy** of accident and health insurance. They will receive this policy on applying to First Choice Next within 30 days after reaching the limiting age and paying the policy's premium. The **policy** will provide the coverage then being issued by First Choice Next that is closest to, but not greater than, the ended coverage. Any probationary or waiting period set forth in this **policy** will be met to the extent coverage was in force under the prior **policy**.

If you have a child with a mental, physical, or developmental disability who is incapable

of earning a living, the child may stay eligible for **dependent** health **benefits** beyond age 26 if all of the following are true:

- The child is and remains incapable of self-sustaining employment because of intellectual disability or physical handicap. The condition started before the child reached age 26.
- The child was covered under this or any other health plan before the child reached age 26 and stayed continuously covered after reaching age 26.
- The child depends on you for most or all of their support.

For the child to stay eligible, you must provide our health plan and the federal Exchange written proof that the child:

- Is mentally, physically, or developmentally disabled
- Depends on you for most of their support
- Is incapable of earning a living

You have 31 days from the date the child reaches age 26 to do this. We may at times ask you to confirm that your child's condition hasn't changed. We will not ask for this confirmation more than once a year.

Per all applicable requirements of Public Law 110-381, known as Michelle's Law, we will extend coverage for a child enrolled in a postsecondary educational institution during a **medically necessary** leave of absence.

When coverage begins

If you are newly enrolled in our health plan and have paid your first month's **premium**, your coverage will start on the **effective date** on your member ID card. No health services received before the **effective date** are covered.

If you were previously a **member** of the health plan in the past 12 months, your **premium** payments must be up to date for the past **plan year** before we can renew this **policy**. If there is any balance due for the prior **plan year**, any payment you make toward a new or renewing **policy** will be applied to that outstanding balance before it is applied to the new **policy premium**. You must make the first month's **premium** payment for coverage to start.

Enrollment periods

You will typically enroll in a plan during the annual enrollment period. This period generally runs from November 1 through December 15 each year. During this period, you can also choose to change your health plan.

If you have a change in circumstances, you may be eligible for a **special enrollment period** within 60 days of that event per with South Carolina and federal law and regulation. Events that may qualify for a **special enrollment period** include:

- Birth or legal adoption of a child
- Marriage
- Loss of other health insurance coverage
- New loss of, or eligibility for, federal subsidy programs
- Change in your permanent address
- Placement of a **foster child**

Enrolling dependents

Dependents who have a qualifying event as defined by state and federal law can be enrolled in our health plan outside of the open enrollment period. They can enroll during a **special enrollment period**. A **dependent** who becomes aware of a qualifying event may enroll during the 60 calendar days before or after the **effective date** of the event. However, coverage will not start before the day of the qualifying event. If a **dependent** is not enrolled when they first become eligible, the **dependent** must wait until the next open enrollment period to enroll, unless they enroll under the **special enrollment period**. This requirement is waived when a parent needs to enroll a child due to an administrative or a court order. Eligibility for your **dependent** child will last until the end of the calendar year that the child turns 26.

You must submit an enrollment application asking for coverage for **dependents** who become eligible after the original **policy effective date**. You will need to provide any **premium** that may be due. You may also need to provide any documentation to show the **effective date** of the qualifying event with the application. You will be notified of coverage approval, the **premium** amount, and the **effective date** of coverage for the **dependent**.

A newborn **dependent** child of the **subscriber** is automatically covered for the first 30 days of life. Coverage includes services due to injury or sickness, needed care and treatment of medically diagnosed congenital defects and birth abnormalities, and routine care given any infant from the moment of birth. If you want to continue enrollment of the newborn beyond the 31st day, you will need to enroll the newborn within 31 days of the date of birth.

If the **dependent** is a newly adopted child or **foster child**, the **effective date** of coverage is the date of the adoption or placement for adoption, or the placement for foster care. An eligible adopted child must be enrolled within 31 days from the legal date of the adoption. We will give **benefits** to your adopted child under the same terms and conditions that apply to naturally born **dependent** children. This applies whether the adoption has become final when your adopted child's coverage becomes effective. A **foster child** must be enrolled within 31 days from the date of placement in the foster home.

The **premium** may change because of adding the newborn, **foster child,** or adopted child to your coverage. If it changes, you will need to pay the full **premium** amount for the newborn within 31 days of the date of birth or 30 days of the legal adoption date or placement of the **foster child**.

Changes in eligibility

You will need to let us know of any changes that might affect your eligibility or the eligibility of any **dependents** for coverage under this **policy**. You must let us know within 60 days of the change. These changes include, but are not limited to:

- Change in your permanent address
- Change in your phone number
- Change in your marital status
- Change in **dependent** status (including changes in the number of **dependents**)
- Changes in age
- You or your **dependent** get other insurance coverage that may impact you or your **dependents**' eligibility. Examples include a health plan through an employer or a program like **Medicare**.

We will extend coverage for a child enrolled in a postsecondary educational institution during a **medically necessary** leave of absence. If there are changes to your marital status, on the entry of a valid decree of divorce between the **subscriber** and the insured spouse, the divorced spouse is entitled to have issued to them an individual **policy** of accident and health insurance. This can be issued without evidence of insurability, on application made to the **insurer** within 60 days following the entry of the decree, and on payment of the suitable **premium**.

End of coverage — termination of enrollment

For **Qualified Health Plans** purchased through the **Exchange**, First Choice Next will only

end your enrollment through the **Exchange** as permitted by the **Exchange** in accordance with 45 CFR 156. 270 and South Carolina law. If your coverage ends for any of the reasons below, your last day of coverage will be the last day of the month for which you have paid your **premium**. **End of coverage** for you will also end coverage for any **dependents** who may be enrolled in our health plan with you under this **policy**. If your coverage ends, we will send you written notice 31 days before ending your coverage. First Choice Next may nonrenew, discontinue, or end your coverage in accordance with federal and state law.

Reasons for ending coverage may include:

- For an enrolled child **dependent**, the end of the calendar year in which they turn 26.
- Loss of eligibility if you are no longer living in the **service area** served by our plan.
- If **premiums** are not paid when they are due. In this case, we will give you 15 days' advance written notice of pending termination before ending coverage. Please refer to the payment of **premiums** section of this **policy** for additional information on grace periods allowed for delinquent premium amounts due.
- Discontinuation of this plan. In this case, we will give you 90 days' advance written notice before ending coverage. We will provide you with the option to purchase a different health insurance plan offered by First Choice Next in the individual market.
- Discontinuation of all of our plans in the South Carolina Exchange. In this case, we will give you 180 days' advance written notice before ending coverage.
- Fraud, including improper use of your member ID card.

If a child **dependent** reaches their age limit and First Choice Next accepts your premium after the date your coverage will no longer be effective, the coverage under this **policy** will continue in force until the end of the period for which the premium has been accepted. In the event the age of the **dependent** child has been misstated and if, according to the correct age of the child **dependent**, the coverage provided by this **policy** would not have become effective or would have ceased prior to the acceptance of the **premium** or **premiums**, then First Choice Next will issue you a refund, upon request, of all **premiums** paid for the period not covered by this **policy**.

If we end your coverage or enrollment in a **Qualified Health Plan** purchased through the **Exchange**, we will promptly and without undue delay, provide you with a notice of the end of coverage that includes the effective date your coverage ends and the reason your coverage ended.

Rescission in coverage

First Choice Next does not rescind coverage of an individual who is covered under this

policy after the **policy** becomes effective unless the individual has performed an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact, as prohibited by the terms of this **policy**.

Payment of premiums

Coverage will not begin until the initial **premium** payment is made. Each **premium** payment is to be paid on or before its due date. First Choice Next will provide you at least 31 days' prior written notice of any premium rate increases from the date the increase becomes effective.

Premium payments are due in advance for each calendar month. Monthly payments are due on or before the first day of each month for coverage for that month. We will give you notice of any **premiums** due at least 10 days before the due date. No premium is considered past due unless we have given you this notice. After paying your first **premium**, you will have a grace period after the next **premium** due date to pay your next **premium**. This **policy** has a 31-day grace period for those not receiving a federal premium tax credit (Advance Premium Tax Credit) and 3 consecutive months for those receiving a federal premium subsidy. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the **policy** will stay in force. If we don't receive full payment of your **premium** within the grace period, we will send you a second notice of such payment delinquency. This notice will advise that your coverage will end as of the last day of the last month for which a **premium** has been paid within 10 days of your coverage ending. We will also notify you of the nonpayment of **premium** and pending termination. We will also notify you of the coverage ending if we have not received the **premium** within the grace period.

For those receiving a federal **premium** subsidy, we will still pay for all suitable claims during the first month of the grace period, but may pend claims for services received in the second and third months of the grace period. We will also notify the **subscriber** of the nonpayment of **premiums**. We will notify **the Department of Health and Human Services** of payment delinquency and any **providers** of the possibility of claims being denied when the **member** is in the second and third months of their grace period, if applicable. We will continue to collect federal **premium** subsidies from the U.S. Department of the Treasury for the **subscriber** and any enrolled **dependents**. If the delinquent premiums amounts are not paid by the end of the 3 consecutive month grace period, First Choice Next will end your enrollment through the **Exchange**. In this instance, we will return subsidies for the second and third months of the grace period at the end of the grace period. This will occur if the **premium** amount owed is not paid and coverage ends for the **subscriber** and any **dependents**. A **subscriber** cannot enroll again once coverage ends this way, unless they

qualify for a **special enrollment period** or during the next open enrollment period.

Reinstatement of coverage

If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by First Choice Next or by an agent authorized to accept payment without requiring an application for reinstatement will reinstate the policy. If First Choice Next or its agent needs an application, the insured will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 45th day after the date of the conditional receipt. This will occur unless the First Choice Next has previously written the insured of its disapproval. The reinstated policy will cover only loss that comes from:

- An injury sustained after the date of reinstatement, or
- Sickness that starts more than 10 days after such date

In all other ways, the rights of the insured and First Choice Next will stay the same. They are subject to any provisions noted on or attached to the reinstated policy. Any premiums First Choice Next accepts for reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days before the reinstatement date.

Certificate of creditable coverage

We will give you a **certificate of creditable coverage** when you or your **dependents'** coverage ends under this **policy** or your continuation of coverage ends. Keep this certificate in a safe place. You can also request a **certificate of creditable coverage** while you are still covered under this **policy** and for up to 24 months after your coverage ends. To do so, call Member Services at the number listed on your member ID card.

How to Use Your Health Plan

Our plan uses **network providers** to give covered services to you. This means we will not pay for services you might get from **out-of-network providers** unless:

- You have an **emergency medical condition** or
- We authorize services from an **out-of-network provider** because the **medically necessary** services you need are not available from a **network provider**.

If we authorize **out-of-network** services, your cost-share needs will be at your **in-network** cost share, unless otherwise stated in your **Schedule of Benefits**. You can find a **network provider** through our online **provider** directory at https://amerihealthcaritasnext.healthsparq.com/healthsparq/public/#/one/city=&state=&postalCode=&country=&insurerCode=ACNEXT_I&brandCode=ACNEXT&alphaPrefix=&bcbsaProductId=&productCode=SCEXv. You can also call our Member Services number on your **member** ID card. This number is also at the end of this policy in How to Contact Us. **Network providers** are not employees of our plan.

This health plan's **benefits** are limited to the **covered health services** included in this **policy**. What we will pay and any **cost-sharing** you may need to pay are also outlined in the **Schedule of Benefits**. All **covered health services** are subject to the limits and exclusions contained in the Exclusions and Limits section of this **policy**. Covered health services are included in your **benefits** under this **policy** and eligible for reimbursement at the contracted rate when they are given through the practice of a duly licensed:

- Optometrist
- Podiatrist
- Licensed clinical social worker
- Certified substance use counselor
- Dentist
- Chiropractor
- Psychologist
- Pharmacist
- Advanced practice **nurse**
- **Physician** assistant

You can see any **in-network** specialist you choose without a referral including services with a dermatologist. First Choice Next provides direct access to **in-network** health care

professionals who specialize in obstetrics or gynecology without the need for a referral or prior authorization. If you use a **network provider**, the **provider** will bill us for any **covered health services** they give. You will need to pay any **deductibles**, **copayments**, and **coinsurance** outlined in your **Schedule of Benefits**. You will also need to pay for any non-**covered health services**.

This means we will not pay for services you might get from **out-of-network providers** unless:

- You have an **emergency medical condition**, or
- We authorize services from an **out-of-network provider** because the **medically necessary** services you need are not available from an **in-network provider**.

If we authorize out-of-network services, your cost-share needs will be at your **in-network** cost share.

Note: Your actual expenses for covered services may exceed the stated **coinsurance** percentage or copayment amount because actual **provider** charges may not be used to determine your and our payment needs.

First Choice Next plans comply with the provisions of the No Surprises Act of the 2021 Consolidated Appropriations Act. Our plans also comply with any associated rules or regulations that the Centers for Medicare and Medicaid Services (CMS) or other regulatory authorities may issue. The **member** will not be penalized and will not incur out-of-network benefit levels unless participating providers able to meet the **member's** health needs are available without unreasonable delay.

Choosing a primary care provider (PCP)

Once you enroll, you and any covered **dependents** in this plan must choose a **PCP**. If you do not choose one, we will pick one for you. You can also change your **PCP** if the **PCP** is no longer a **network provider**. Your **PCP** will oversee your care and order services from other **network providers** when needed. In certain cases, if you have been diagnosed with a serious or chronic degenerative, disabling, or life-threatening condition or disease, you may select a specialist to serve as your **PCP**. This choice will be subject to our health plan's approval. The specialist must have expertise in treating your disease or condition. They must be responsible for and able to give and manage your primary and specialty care. If we find that your care would not be suitably managed by that specialist, we may not allow that specialist to be chosen as a **PCP**. You will be allowed to choose an **in-network** pediatrician as the **PCP** for any covered **dependents** under age 18.

Continuity and transition of care

First Choice Next is responsible for determining if a **covered person** qualifies for **continuation of care** and may request additional information in reaching such determination. Upon receipt of the patient's request for **continuation of care** accompanied by the **physician's** attestation on the prescribed form, the **issuer** shall notify the **provider** and **the covered person** of the **provider's** date of termination from the **network** and of the **continuation of care** provisions. Subject to **prior authorization** and **medically necessary** criteria review, for 90 days after the **effective date** of a new **member's** enrollment (or until treatment is completed, if less than 90 days), we will cover **out-of-network covered health services** with your treating **provider** for any medical or **behavioral health** condition being treated when the **member** enrolls in our plan. If the **member** is pregnant and in their second or third trimester, pregnancy-related services will be covered through 60 calendar days after the birth. **Covered benefits** rendered through **continuation of care** by a **provider** to a **covered person** for a **serious medical condition** are subject to the **policy's** regular benefit limits. Your **policy** does not require a **covered person** to pay a **deductible** or **copayment** which is greater than the **in-network** rate for services rendered during the **continuation of care**. First Choice Next does not require a **covered person**, as a condition of continued coverage under the **plan**, to pay a **premium** or contribution which is greater than the **premium** or contribution for a similarly situated individual enrolled in the **plan** on the basis of **covered benefits** rendered as provided for in this section to the **covered person** or the **dependent** of a **covered person**.

If an **in-network provider** stops participating in our **in-network**, they become an **out-of-network provider**. If you are in active treatment for a serious condition or illness when this occurs, you may continue getting care from that **out-of-network provider**. This care will end when treatment for the condition is completed or you change to a **network provider**, whichever comes first. We will notify you if your **in-network provider** becomes an **out-of-network provider**. The **out-of-network provider** treating you may not bill you more than your **in-network** cost-share for up to 90-days after you are notified.

To get these services, you must obtain **prior authorization** from the **health benefit plan**. Pregnant **members** in their second or third trimester of pregnancy and who have started prenatal care with a **provider** who stops participating in our **in-network** can continue receiving prenatal care through the date of birth of the baby and 60 days after the birth. This continuity of care allowance does not apply to **providers** who have been ended for cause as **network providers** by the plan.

If you are found to be terminally ill when your **provider** stops participating in our **network**, or at the time you enroll in our plan, and your **provider** was treating your terminal illness before the date the **provider** stops participating or your new enrollment in our plan, you can continue to receive care from that **provider**. However, this is only true for services

that directly relate to the treatment of your illness or its medical effects.

Medical necessity

Covered **benefits** and services under our plan must be **medically necessary**. We use clinical criteria, scientific evidence, professional practice standards, and expert opinion to decide medical necessity. The cost of services and supplies that are not **medically necessary** will not be eligible for coverage. They will not be applied to **deductibles** or out-of-pocket amounts.

Prior authorization

We may need to review certain services or supplies before you receive them to make sure they are **medically necessary** and being given by a **network provider**. If you are receiving services from a **network provider**, the **provider** will be responsible for getting any needed **prior authorization** before you get services. If the **prior authorization** is denied and the **provider** still gives you these services, the **provider** cannot bill you for these denied services unless you agreed to receive services at a self-pay rate. If you are getting services outside of our **service area** or from an **out-of-network provider**, you will need to make sure to get any needed **prior authorization** before receiving services. If you do not, the service may not be covered under this plan.

Prior authorization can be taken back after **emergency services** are given if you or your **provider** materially misrepresented your condition. Coverage will also depend on any limits or exclusions for this plan, payment of **premium**, eligibility at the time of service, and any **deductible** or **cost-sharing** amounts. If you do not get **prior authorization** before an elective admission to a **hospital** or certain other facilities, you may need to pay all charges for services that do not meet **prior authorization** requirements.

This list of physical or **behavioral health** services needing **prior authorization** may change. For the most current information, please visit or have your **provider** visit the **prior authorization** section of the plan website.

Physical health services requiring prior authorization

- All out-of-network services, except for emergency services
- All services that may be considered experimental and/or investigational
- All miscellaneous services
- Chemotherapy
- Chiropractic services
- Cochlear implantation

- Congenital cleft lip and palate oral and facial surgery or orthodontic services
- Dental anesthesia
- **Durable medical equipment (DME)**:
  - All unlisted or miscellaneous items, regardless of cost
  - **DME** leases or rentals and custom equipment
  - Items with billed charges equal to or greater than $750
  - Negative pressure wound therapy
  - Prosthetics and custom orthotics
- Elective air ambulance
- Elective procedures including, but not limited to, joint replacements, laminectomies, spinal fusions, discectomies, vein stripping, and laparoscopic or exploratory surgeries
- First- and second-trimester terminations of pregnancy need **prior authorization** and are covered in the following two circumstances:
  - The **member's** life would be endangered if they were to carry the pregnancy to term
  - The pregnancy is the result of an act of rape or incest
- Gastric restrictive procedures or surgeries
- Gastroenterology services
- Genetic testing
- Home-based services
- **Home health aide** services
- **Home health care services** including, but not limited to, physical, occupational, speech, and language therapy, and skilled nursing services. Prior authorization is needed after any combination of six home health care service visits are received to allow coverage for any more home health care services.
- Home infusion services and injections
- **Hospice** inpatient services
- Hyperbaric oxygen

- Hysterectomy (Hysterectomy Consent Form needed)
- Inpatient **hospital services**:
  - All inpatient **hospital** admissions, including medical, surgical, long-term acute, skilled nursing, and rehabilitation
  - Elective transfers for inpatient and/or outpatient services between acute care facilities
  - Medical detoxification
  - Obstetrical admissions and newborn deliveries exceeding 48 hours after vaginal delivery and 96 hours after cesarean section
- **Medically necessary** contact lenses
- Pain management including, but not limited to:
  - Epidural steroid injections
  - External infusion pumps
  - Implantable infusion pumps
  - Nerve blocks
  - Radiofrequency ablation
  - Spinal cord neurostimulators
- Personal care services, or help with activities of daily living, including bathing, eating, dressing, toileting, and walking
- Post-mastectomy inpatient care. Note: Inpatient discharge decisions after mastectomy procedures will be made by the attending physician in discussion with the patient. Length of post-mastectomy inpatient stays are based on the unique needs of each patient. Needs relate to the patient's health and medical history.
- Reconstructive breast surgery (following a mastectomy). Breast reconstruction is covered regardless of the time elapsed between the mastectomy and the reconstruction. These **benefits** will be provided subject to the same **deductibles** and **coinsurance** that apply to other medical and surgical **benefits** given under this plan. To learn more, please call the number on the back of your First Choice Next member ID card.
- **Rehabilitation services** and **habilitative services** (speech, language, occupational, and physical therapy):

  - Speech, language, occupational, and physical therapy need **prior authorization** after initial assessment or reassessment. This applies to private and outpatient **facility**-based services.

- Skilled nursing care
- **Surgical services** that may be considered cosmetic, including:
  - Blepharoplasty
  - Breast reconstruction not associated with a diagnosis of breast cancer
  - Mastectomy for gynecomastia
  - Mastopexy
  - Maxillofacial surgery
  - Panniculectomy
  - Penile prosthesis
  - Plastic surgery/cosmetic dermatology
  - Reduction mammoplasty
  - Septoplasty
- The following radiology services, when performed as outpatient services, may need **prior authorization**.
  - Computed tomography (CT) scan
  - Magnetic resonance imaging (MRI)
  - Magnetic resonance angiography (MRA)
  - Nuclear cardiac imaging
  - Positron emission tomography (PET) scan
- Transplants, including transplant evaluations

Physical health services that do not need prior authorization

Subscribers and their **dependents** do not need **prior authorization** to see a PCP, go to a local health department, or receive services at school-based clinics.

The following services will not need **prior authorization**:

- 48-hour observation stays (except for maternity delivery and cesarean section surgery, when **physician** notification is needed)
- Electrocardiograms (EKGs)

- Emergency care (**in-network** and **out-of-network)**
- Dialysis
- Family planning services
- Low-level plain film X-rays
- Postoperative pain management (must have a surgical procedure on the same date of service)
- Pediatric routine vision services
- Women's health care by **network providers** (OB/GYN services)

Behavioral health services needing prior authorization

- All out-of-**network** services, except **emergency** care
- Ambulatory detoxification
- Electroconvulsive therapy (ECT)
- Medically supervised alcohol or drug use treatment center detoxification crisis stabilization/Alcohol and Drug Abuse Treatment Center (ADATC; following the first eight hours of admission)
- Mobile crisis management
- Nonhospital medical detoxification
- Intensive outpatient treatment for opioid substance use treatment
- Partial hospitalization
- Professional treatment services in **facility**-based crisis programs (following the initial seven days/112 units)
- Psychiatric inpatient hospitalization
- Psychological testing

Behavioral health services that do not need authorization

- Diagnostic assessment
- Medication-assisted treatment (MAT)
- Mental health or substance dependence assessment
- Psychiatric and substance use disorder outpatient and medication management services

Utilization Management

We use our Utilization Management program to help ensure you get suitable, affordable, and high-quality care that adds to your wellness. Our Utilization Management program focuses on both the **medical necessity** and the outcome of physical and **behavioral health** services, using prospective, concurrent, and retrospective reviews. For all decisions, we use documented **clinical review criteria** based on sound clinical evidence. We periodically evaluate the evidence to ensure ongoing efficacy. We obtain all information needed to make **utilization review** decisions, including pertinent clinical information. A **provider** can ask for a review for the insured. Retrospective review includes the review of claims for **emergency services** to find whether the applicable prudent layperson legal standards have been met.

We will:

- Routinely assess the effectiveness and efficiency of our **utilization review** program.
- Coordinate the **utilization review** program with our other medical management activities. These include quality assurance, credentialing, **provider** contracting, data reporting, **grievance** procedures, processes for assessing satisfaction of **covered persons**, and risk management.
- Give **covered persons** and their **providers** access to our review staff via a toll-free phone number or collect call whenever any **provider** needs to give services that may need prior certification or authorization to any plan **member**. The department's clinical staff and medical directors are available and accessible to all **providers** and **members** from 8:00 a.m. to 5:00 p.m., Monday through Friday, with the exception of company observed holidays. Just call our toll-free number at 1-877-486-7229 Utilization Management clinical staff are available on call after normal business hours, weekends, and holidays by calling XXX-XXX-XXXX. A toll-free fax line is available to receive inbound communications from **providers** 24 hours a day, 7 days a week at 1-833-727-7329. TTY and language help is also available at 711.
- Limit our requests for information to only that information needed to certify or authorize the admission, procedure, or treatment; length of stay; and frequency and duration of **health care services**.
- Provide written procedures for making **utilization review** decisions and notifying **covered persons** of those decisions.
- Have written procedures to address the failure or inability of a **provider** or **covered person** to give all needed information for review. If a **provider** or **covered person**

fails to release needed information in a timely manner, the **insurer** may deny certification.

We will make review decisions after receiving all of the needed information about the requested service. Needed information may include, but is not limited to, clinical notes, clinical evaluations, and **second opinions** from a different clinician. Within these time frames, we will notify your provider of our review determination, whether adverse or not:

- Concurrent requests are decided and communicated within 24 hours from the date of receipt.
- Urgent care prospective requests are decided and communicated as soon as possible, taking into account medical needs, but will not exceed 72 hours from the date of receipt.
    - A prospective request is considered urgent if it is found that a delay in the decision could reasonably appear to seriously jeopardize the life or health of the **member** or jeopardize the **member's** ability to regain maximum function or in the opinion of a **physician** with knowledge of the **member's** medical condition, would subject the **member** to severe pain that cannot be adequately managed without the requested care or treatment.
- From the date of receipt, nonurgent care prospective requests are decided and communicated within five calendar days if received electronically. They are decided within eight business days if received from a non-electronic source.
- Retrospective requests are decided and communicated within 30 calendar days from the date of receipt.

Notification of utilization management decisions will be consistent with South Carolina law and our policies. We may ask for more information from you or your **provider** to help us decide. We will allow the following extensions of the above time frames for you or your **provider** to send this additional information based on the type of request:

- 45 calendar days for retrospective requests
- 45 calendar days for non-urgent care prospective requests
- 72 hours for concurrent requests
- 48 hours for urgent care prospective requests

If a **provider** or **member** fails to release needed information in a timely manner, we may deny certification of the requested service. You may appeal the decision to deny certification or authorization.

If we have approved a course of treatment to be provided over a period of time or number of treatments:

- Any reduction or ending by us of such course of treatment (other than by plan amendment or ending) before the end of such period of time or number of treatments shall constitute an **Adverse Benefit Determination**. We will notify the **member** of the **Adverse Benefit Determination**. We will notify enough in advance of the reduction or termination to allow the **member** to **appeal** and get a decision on review of that **Adverse Benefit Determination** before the benefit is reduced or ended.
- A member can ask to extend the course of treatment beyond the prescribed time or number of treatments. In certain cases, we will make a benefit decision as soon as possible. This is the case when delay in the decision could reasonably appear to:
  - Seriously jeopardize the life or health of the **member**
  - Seriously jeopardize the **member's** ability to regain maximum function
  - In the opinion of a **physician** with knowledge of the **member's** medical condition, would subject the **member** to severe pain that cannot be adequately managed without the care or treatment that the **member** is requesting.

  In deciding, we will consider any urgent medical needs. For concurrent and prospective requests received by the plan at least 24 hours before the end of the prescribed period of time or number of treatments, we will notify the **member** of the benefit determination, whether adverse or not, within 24 hours for concurrent requests and within 72 hours for prospective requests after we receive the request. Notification of any **Adverse Benefit Determination** on a request to extend the course of treatment shall be made in accordance with this plan.

If we certify or authorize a health care service, we will notify the **member** and the **member's provider**. For an **Adverse Benefit Determination**, we will notify the **member's provider** and send written or electronic confirmation of the **Adverse Benefit Determination** to the **member**. For concurrent reviews, we will be responsible for **health care services** until the **member** has been notified of the **Adverse Benefit Determination**. In other words, decertification does not become effective until notice is given to the **covered person**. For retrospective reviews, we will notify your **provider** in writing of our decision. If we deny the service as a result of the review, we will send written notice to both you and your **provider** after the decision is made. We remain responsible for **health care services** until you have been notified of the **Adverse Benefit Determination**. We will notify you orally or in writing.

To get **prior authorization** or verify requirements for inpatient or outpatient services, including which other types of **facility** admissions need **prior authorization**, you or your **provider** can call us at 1-833-983-7272.

Cost-sharing needs

In addition to the monthly **premium**, the amount you will have to pay for **covered health services** may include a **deductible**, **coinsurance**, and **copayments**. First Choice Next negotiates rates with providers for **covered health services** under this **policy**. Our contract with **network providers** for **covered health services** may be at a discounted rate of payment. If so, your **deductible** and **cost-sharing** amounts will be based on the discounted rate of payment. Your specific **cost-sharing** amounts may differ for various services and can be found in your **Schedule of Benefits**.

- A **copayment** or **copay** is your share of the cost for covered services or prescription drugs that you pay as a set dollar amount.
- **Coinsurance** is your share of the cost for covered services or prescription drugs that you pay, usually shown as a percentage of the **allowed amount** for a **covered health service**.
- The **out-of-pocket maximum** amount is the most you may pay out of pocket during the year for covered services. This does not include any amounts you pay for **premiums**.
- Your **deductible** is the amount you will have to pay each year for covered services before the health plan begins to pay. Any **coinsurance** or **copayment** amounts will not apply to your **deductible,** but will count toward your **out-of-pocket maximum** amount.

Covered Health Services

This section describes the services for which coverage is available. Please refer to the **Schedule of Benefits** for details about:

- The amount you must pay for these **covered health services** (including any **deductible**, **copayment**, and/or **coinsurance**).
- Any limits that apply to these **covered health services** (including visit, day, and dollar limits on services).
- Any limit to the amount you need to pay in a calendar year (**out-of-pocket maximum** amount).

You can ask for the **Schedule of Benefits** and other **policy** documents. Just call Member Services at 1-833-983-7272, 8 a.m. – 8 p.m., 5 days a week. You may also access **policy** documents online at www.firstchoicenext.com.

Please refer to the How to Use Your Health Plan section of this policy to see whether services may need **prior authorization**.

Abortion services

We will only cover abortion services in cases of rape, incest, or when the mother's life is in danger.

Accident-related dental services

Outpatient and office visit services received for dental work and oral surgery are covered if they are for the initial repair of an injury to the natural teeth, mouth, jaw, or face that results from an **accident** and are **medically necessary**. Initial repair for injuries due to an **accident** means services must be requested within 60 days from the date of injury. They must also be given within six months of the date of injury and include all examinations and treatment to complete the repair.

Allergy testing and treatment

We cover **medically necessary** allergy testing and treatment, including allergy shots and serum only when administered by an **in-network provider** in an office visit setting.

Ambulance services

We cover ambulance services by ground, air, or water for an **emergency**. Services must be given by a licensed ambulance service **provider**. The service must take you to the nearest **hospital** where **emergency** care can be provided.

We also cover nonemergency ambulance rides by a licensed ambulance service (by

ground, air, or water) when the ride is:

- From an acute **facility** to a subacute **facility** or setting.
- From an out-of-network **hospital** or **facility** to an **in-network hospital** or **facility**.
- To a **hospital** that provides a higher level of care than was available at the original **hospital** or **facility**.
- To a more cost-effective acute care **facility**.

If an out-of-**network** air ambulance transports you, they cannot bill you for more than your **in-network** cost-share. Nonemergency air transportation needs **prior authorization**.

Autism spectrum disorder (ASD)

We will cover the assessment, screening, diagnosis, and treatment of **autism spectrum disorder** for covered individuals younger than age 16. The covered individual must have been diagnosed with an **autism spectrum disorder** before their 9th birthday. **Covered health services** include:

- Behavior training and management and applied behavioral analysis, including, but not limited to, consultations, direct care, supervision, or treatment, or any combination thereof, provided by autism services **providers**.
- Evaluation and assessment services.
- **Habilitative or rehabilitation services**, including, but not limited to, occupational, physical, speech, or language therapy, or any combination of those therapies.
- Pharmacy services and medication as covered under the terms of this **policy**.
- Psychiatric care.
- Psychological care, including family counseling.
- Therapeutic care, which includes behavioral analysis and habilitative or **rehabilitation services.**

Certain services for ASD need **prior authorization**.

Biofeedback

We will cover **medically necessary** biofeedback when provided in a medical office setting.

Bone mass measurement services

We will cover services for bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass if at least 23 months have elapsed since the last bone

mass measurement was performed. We may cover follow-up bone mass measurement more frequently than every 23 months if **medically necessary**. **Bone mass measurement services** will only be covered for individuals who meet certain clinical criteria if for a primary diagnosis other than prevention or wellness. These services need **prior authorization**.

Chemotherapy services

We will cover intravenous chemotherapy treatment as an outpatient service at a **hospital** or other **facility**. **Covered health services** include the **facility** charge and charges for related supplies, equipment, and **physician** services for **covered health services**.

Chiropractic care

We will cover outpatient chiropractic services when performed and found to be medically necessary by a network licensed chiropractor for the treatment or diagnosis of spinal conditions and neuromusculoskeletal disorders. **Covered health services** include an initial office visit, chiropractic manipulative treatment with or without ancillary physiologic treatment, and/or rehabilitative methods to restore/improve motion, reduce pain, and improve function, ultrasound, traction therapy, and electrotherapy. Chiropractic X-rays are covered only for X-rays of the spine. Chiropractic services must either significantly improve your condition in a reasonable and predictable period of time or be needed to establish an effective maintenance program.

The following are excluded from chiropractic and osteopathic services:

- Chiropractic services that are a part of a maintenance program
- Charges for care not given in an office setting
- Infusion therapy or chelation therapy
- Maintenance or preventive treatment consisting of routine, long-term, or not **medically necessary** care to prevent reoccurrences or maintain the patient's current status
- Manipulation under anesthesia
- Services of a chiropractor or osteopath that are not within their scope of practice, as defined by state law
- Vitamin or supplement therapy

Please see the **Schedule of Benefits** for more information and any limits.

Clinical trials

First choice next will not deny a **covered person's** participation in an **approved clinical trial** nor will discriminate against a **covered person** based on their participation in a clinical trial. We will provide coverage of **routine patient care costs for approved clinical trials**.

Complications of Pregnancy

We cover **medically necessary** services and supplies for the treatment of complications of pregnancy. Complications of **pregnancy** will be treated the same as any other illness. A non-elective cesarean section is considered a **complication of pregnancy**.

Congenital cleft lip and palate care and treatment

We will cover **medically necessary** care and treatment including, but not limited to:

- Medical and nutritional services, oral and facial surgery, surgical management, and follow-up care needed for a cleft lip and palate
- Prosthetic treatment such as obturator, speech appliances, and feeding appliances
- Orthodontic treatment and management
- Prosthodontic treatment and management
- Otolaryngology treatment and management
- Audiological assessment, treatment and management performed by or under the supervision of a licensed doctor of medicine, including surgically implanted amplification devices and physical and speech and language therapy assessment and treatment

If a **member** with a cleft lip and palate is covered by a dental policy, teeth capping, prosthodontics, and orthodontics shall be covered by the dental policy to the limit of coverage given. Any excess thereafter shall be provided by this plan.

Diabetes services and supplies

We cover services, equipment, and supplies for the treatment of diabetes mellitus if it is **medically necessary** and a **network provider** prescribes it. Please see the Prescription Drugs section of this policy to learn more about your prescription drug coverage for diabetes medication and supplies. The following is a list of diabetes services and supplies covered under your **policy** when received from a **network provider:**

- Diabetes care management and monitoring equipment, including certain supplies that may be covered under your pharmacy benefit.

- Diabetes education when a **network provider** who specializes in the treatment of diabetes certifies that services are **medically necessary**.
- Exams, including diabetic eye examinations and foot examinations.
- Insulin pumps and supplies needed for the insulin pumps.
- Outpatient medical nutrition therapy services ordered by a physician and provided by suitably licensed or registered health care professionals.
- Podiatric appliances for the prevention of complications associated with diabetes.
- Routine foot care.

Diagnostic services — outpatient

We cover laboratory, X-ray, and radiology services done to diagnose disease or injury. Outpatient diagnostic services or imaging may be given at a **hospital**, alternate **facility**, or **physician's** office. Specific diagnostic services for preventive care can be found in the preventive **health care services** section below.

Dialysis services — outpatient

We cover dialysis treatments received as an outpatient from a **network provider**, including outpatient dialysis centers and **physician** offices.

Durable medical equipment (DME) and devices

We cover **medically necessary DME** ordered or given by a **physician**. **DME** may need a **prior authorization**, and we reserve the right to approve rental instead of purchase of the **DME**. Examples of **DME** include, but are not limited to, crutches, orthotics (including for positional plagiocephaly), **prosthetics**, and wheelchairs.

Emergency services

We will cover services needed to start treatment and **stabilize** your **emergency medical condition**. These services may include a **hospital** or **facility** charge, supplies, and related professional services. If you are admitted to the **hospital** from the emergency room, any applicable **copay** for emergency room services will not apply. If you are admitted to an **out-of-network hospital** from the emergency room, you must notify us within 24 hours. When you are **stabilized**, we will transfer you by ambulance to the closest suitable **in-network hospital** or **facility**. Coverage will only apply if the condition meets the definition of an **emergency medical condition**, but you do not need to notify us in advance before seeking treatment for an **emergency**. **Emergency services** and some post-stabilization services received from an **out-of-network provider** will be covered at the **in-network** benefit level. The **out-of-network provider** cannot bill you more than your **in-network**

cost share. Emergency services are covered without the need for prior authorization whether received from an **in-network** or **out-of-network provider**. If emergency services are received from an **out-of-network provider**, First Choice Next will not impose any administrative requirements or limitation on coverage that is more restrictive than the administrative requirements or limitations on coverage for **in-network providers**.

Family planning services

Family planning services covered under this plan include:

- Counseling and education about family planning
- Injectable contraceptive medication given by a physician
- Intrauterine devices, including insertion and removal
- Surgical sterilization (vasectomy, tubal ligation) contraceptive medications, if they are covered under your pharmacy benefit

We will also cover any **medically necessary** test for use of the prescribed contraceptive drug or device. **Prior authorization** may be needed for certain family planning services.

The following services are excluded from coverage under your **policy**. These will not be covered:

- Abortion, unless the abortion is needed to save the life or health of the member, or as a result of incest or rape
- Fetal reduction surgery
- Infertility
- Reversal of sterilization or vasectomies
- Services related to surrogate parenting

Habilitative services

Medically necessary habilitative services that help you keep, learn, or improve skills and functioning of daily living. These services may include occupational therapy. Physical therapy must be ordered by a physician and delivered by suitably licensed medical personnel. We will determine if the service is covered by reviewing both the skilled nature of the service and the need for physician management. These services may be provided in an inpatient or outpatient setting.

Covered health services also include chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods given to restore or improve motion, reduce pain, and improve function. This applies when a **network** chiropractor

finds that the outpatient services are **medically necessary** to treat or diagnose neuromusculoskeletal disorders.

The following are excluded from chiropractic and osteopathic services:

- Charges for care not provided in an office setting
- Infusion therapy or chelation therapy
- Maintenance or preventive treatment consisting of routine, long-term, or not **medically necessary** care provided to prevent reoccurrences or to maintain the patient's current status
- Manipulation under anesthesia
- Services of a chiropractor or osteopath that are not within their scope of practice, as defined by state law
- Vitamin or supplement therapy

Please see the **Schedule of Benefits** for more information and any limits.

Home health care

We will cover certain services received in the home from a certified or licensed home health agency when ordered by a physician. Examples of these services include skilled care; physical, occupational, speech, language, and respiratory therapy; social work services; and home infusion. Services must only be provided on a part-time, intermittent basis. They cannot be solely for helping with activities of daily living. Please see your **Schedule of Benefits** for more information and any limits that may apply.

Hospice care

Hospice care is a comprehensive program of care that addresses the physical, social, and spiritual needs of a terminally ill patient and helps support the immediate family. Services will be covered when recommended by a **physician** and received from a suitably licensed **hospice** agency or inpatient **hospice** program. **Hospice** care services are limited to six months of care per episode.

Hospital services

This plan covers inpatient **hospital services** and **physician** and surgical services for treatment of an illness or injury and associated services and supplies for this care, including anesthesia, subject to **prior authorization**. Treatment may need inpatient services when they cannot be adequately provided on an outpatient basis.

This plan also covers outpatient **hospital services** for diagnosis and treatment, including

certain surgical procedures.

Outpatient **hospital services** for **emergency** care are covered per the **emergency services** section above.

Lymphedema services

We will cover services related to the diagnosis, evaluation, and treatment of lymphedema. This coverage includes **medically necessary** equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education.

Mastectomy and breast cancer reconstruction

Benefits are provided for mastectomy and breast reconstruction done in an inpatient or outpatient setting for the following when found to be **medically necessary** by the **member's** attending physician, subject to the approval of First Choice Next:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the non-diseased breast to produce symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Inpatient discharge decisions following mastectomy procedures will be made by the attending physician in discussion with the patient. Length of post-mastectomy inpatient stays are based on the unique needs of each patient, considering their health and medical history. Your policy gives hospitalization coverage for 48 hours after your mastectomy. You may be released before the 48-hour coverage ends, if your attending physician deems the discharge medically suitable. If you are released before the end of your 48-hour window, your coverage will include at least one home health care visit if ordered by your attending physician.

Breast reconstruction is covered regardless of the time elapsed between the mastectomy and the reconstruction. These **benefits** will be given subject to the same **deductibles** and **coinsurance** that apply to other medical and surgical **benefits** under this plan. To learn more, please call the Member Services number on the back of your First Choice Next member ID card.

Mental health and substance use services

Inpatient **behavioral health** services and substance use services are covered when

received in an inpatient or intermediate care setting. Care may be given in a general or psychiatric **hospital**, a residential treatment center, or an alternate **facility**. Substance use services include detoxification and related medical services when needed for the diagnosis and treatment of addiction to alcohol and/or drugs. These services include medication management when provided with a consultation.
We will also cover certain outpatient **behavioral health** services and substance use services. Examples include:

- Day treatment programs
- Diagnostic testing to evaluate a mental condition
- Outpatient office visits
- Outpatient **rehabilitation services** in individual or group settings
- Short-term **partial hospitalization**

Mental health and substance use services are excluded and not covered by your **health benefit plan** when related to:

- Court-ordered services needed for parole or probation
- Marital and relationship counseling
- Testing for aptitude or intelligence
- Testing for evaluation and diagnosis of learning abilities

First Choice Next complies with the federal Mental Health Parity and Addiction Equity Act. We cover mental health and substance use services in parity with medical or surgical **benefits** within the same classification or subclassification.

Other provider office visits

We will cover primary and specialty care office visits with qualifying **providers** who are practitioners other than a **physician**, such as physician assistants or nurse practitioners.

Outpatient facility services (e.g., ambulatory surgery center)

We will cover **facility** charges for **covered health services** given in an outpatient setting for treatment of an illness or injury. This includes, when applicable, surgical services and associated services and supplies for this care, such as anesthesia, with **prior authorization**.

Outpatient surgery physician and surgical services

We will cover professional fees for **covered health services** given in an outpatient setting, with **prior authorization**.

Pediatric vision services

We cover pediatric vision services through the last day of the month in which a child turns age 19. Covered services include:

- One comprehensive low-vision exam every five years and low-vision aids
- One routine eye exam per calendar year
- One pair of eyeglasses (with standard frames and lenses) or contact lenses per calendar year

Please see the **Schedule of Benefits** for more information and any limits.

Physician services for sickness and injury

We cover services given by a **physician**, including specialists, for the diagnosis and treatment of an illness or injury. Services may be given in a **physician**'s office, in a free-standing clinic, at the patient's home, or in a **hospital**.

Pregnancy services

Covered services include prenatal care, delivery, postpartum care, and services for any related complications of pregnancy. We will cover services that include those given by a certified **nurse** midwife or a standalone birthing center. The minimum duration of a covered inpatient stay for a delivery is 48 hours for the mother and newborn after a vaginal delivery or 96 hours for the mother and newborn after a cesarean section delivery. These time frames do not include the day of delivery or surgery. You do not need to get **prior authorization** during this time frame. However, **prior authorization** is needed after the minimum duration inpatient stay expires. The mother could be discharged earlier. If so, timely post-delivery follow-up care will be provided to the mother no later than 72 hours immediately after discharge. Complications of pregnancy are treated the same as any other illness. An **emergency** (non-elective) cesarean section is considered a **complication of pregnancy**.

Coverage also includes well-baby care in the **hospital** or birthing center. Complications of pregnancy are treated the same as any other illness. An **emergency** (non-elective) cesarean section is considered a **complication of pregnancy**.

Prescription drugs

We use a pharmacy **benefits** management (PBM) organization to help manage your prescription drug benefit, including specialty medications. You will need to fill your prescription medications from a **network pharmacy** for it to be covered under your prescription drug benefit. Prescriptions can be filled at either a retail **network pharmacy**

or through our mail-order **network pharmacy**. As with obtaining any service under our plan, you will need to show your member ID card when you fill or get your prescription medications.

The list of prescription drugs covered under this plan is also called a **formulary**. The **formulary** covers both brand (preferred and non-preferred) and generic medications and will determine your **out-of-pocket costs** for medications under our plan. The **formulary** may occasionally change, but we will provide written notice to you before any changes take effect. We will also work with you and your prescriber to switch to another covered medication if you are on a long-term prescription. You can ask for the **formulary** listing. Just call Member Services at 1-833-983-7272, 8 a.m. – 8 p.m., 5 days a week. A searchable **formulary** is available at https://www.firstchoicenext.com/members/find-a-provider-or-pharmacy.aspx. You can enter a medication name to see if it is covered in the **formulary**, what drug benefit tier it is on, and if there are any limits such as **Prior Authorization**, **Step Therapy**, **Quantity Limits**, or Age Limits. There is also a printable **formulary** on the website at insert website address. It shows all of the medications in the **formulary**, their drug benefit tiers, and any limits.

We will cover certain off-label uses of cancer drugs in accordance with state law. We will not exclude coverage for any drug used for cancer treatment on the grounds that the drug has not been approved by the Federal Food and Drug Administration (FDA) for the treatment of a specific type of cancer for which the drug has been prescribed. This is provided that such drug is recognized for treatment of that specific type of cancer in one of the standard reference compendia or in the medical literature. To qualify for off-label use, the drug must be recognized for the specific treatment for which the drug is being prescribed by one of the following four compendia (summaries of drug information that are compiled by experts who have reviewed clinical data on drugs): (1) National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium; (2) The Thomson Micromedex DrugDex®, (3) The Elsevier Gold Standard's Clinical Pharmacology; or (4) any other authoritative compendia as recognized by the United States Secretary of Health and Human Services.

Our PBM may also use certain tools to help ensure your safety and that you get the most suitable medication at the lowest cost to you. These tools include **step therapy**, **quantity limits**, and **prior authorization**. You can learn more about these tools and the medications they are used for in our **formulary** and your **Schedule of Benefits**. **Quantity limits** will be waived in some cases during a state of **emergency** or disaster.

Your pharmacy **formulary** is a closed formulary. This means products not listed on the **formulary** are treated as non-formulary and will not be covered by your **health benefit**

plan. It is possible there is a prescription drug you are currently taking, or one that you and your provider think you should be taking, that is not in our formulary list. You can still ask for drugs not on the **formulary,** including drugs that have not been reviewed for inclusion in the **formulary**. Our PBM's coverage determination and **prior authorization** process allow the chance for non-formulary exceptions.

To ask for coverage of a non-formulary drug, you, your authorized representative, or your prescribing provider may call us at 1-877-472-7979. Or you may fill out the submission form at https://ppa.performrx.com/PublicUser/OnlineForm/OnlineFDBSingleForm.aspx?cucu_id=Y65L6nti7Fh2jJt8A7Rsjw%3d%3d. You can also ask via fax to 1-833-329-7229 or by mail at 200 Stevens Drive, Philadelphia, PA, 19113 CC:26. If sending a request by mail or fax, we suggest you view the online submission form or call us. This may help ensure all needed information is included in your request.

Once First Choice Next receives the request, we will review it for medical necessity and suitability. For a standard exception review, we will make our decision no later than within 72 hours of the date we received the request and any needed additional information. You can ask for an expedited (fast) exception if you, your authorized representative, or prescribing provider think that your health could be seriously harmed by waiting up to 72 hours for a decision. You can indicate your exigent circumstance on your request by asking for an expedited review. We will give you a decision on expedited requests no later than 24 hours after we receive the request and any needed additional information.

If the non-formulary request is denied and you feel we have denied the request incorrectly, you may challenge the decision through First Choice Next's internal dispute process. If a decision is made to uphold the denial pursuant to our internal dispute process, then on exhaustion of that process, you have the right to pursue either a standard or, if warranted and suitable, an expedited external review by an impartial, third-party reviewer known as an Independent Review Organization (IRO). Your denial notice will explain your right to external review and provide instructions on how to make this request. An external review request can be made by you, your authorized representative, or your prescribing provider.

Amounts paid toward reducing the cost sharing incurred by **covered persons** using any form of direct support offered by drug manufacturers for specific prescription drugs may be, but are not required to be, counted toward your annual limitation on cost sharing.

Preventive health care services

We cover any preventive services needed by federal and state laws or regulations. Your **deductible**, **copayment**, or **coinsurance** amounts will not apply if these services are

received from an **in-network provider**. Services ordered by a **network provider** to diagnose or treat a medical condition are not considered a preventive care service. Services received are billed at the suitable cost-share described in your **Schedule of Benefits**.

State and federally mandated preventive health care services

Examples of needed preventive services include, but are not limited to:

- Abdominal aortic aneurysm screening for men ages 65 – 75 who have ever smoked
- Annual mammogram, Pap test, colonoscopy, and colorectal cancer screenings
- Cervical cancer screening. Examination and laboratory tests for early detection and screening include an annual Pap test, liquid-based cytology, and human papillomavirus detection. This will follow American Cancer Society guidelines.
- Colorectal cancer screening. Annual examinations and laboratory tests for colorectal cancer are covered for any **member** who is at least age 50 or older or is younger than age 50 but is at high risk for colorectal cancer.
- Diagnosis and treatment of lymphedema.
- Mammograms/OBGYN. We cover one baseline mammogram for any female member ages 35 – 39, one mammogram per female member every two years beginning at age 40, and one mammogram per female member per benefit period beginning at age 50. This will follow the most recent published guidelines of the American Cancer Society.
- Newborn hearing screening
- Nutritional counseling
- Ovarian cancer screening. We cover, for female **members** ages 25 and older at risk for ovarian cancer, an annual screening, including a transvaginal ultrasound and rectovaginal pelvic examination.
- Preventive care and screenings for infants, children, and adolescents according to guidelines supported by the Health Resources and Services Administration (HRSA)
- Preventive care and screenings for women per the guidelines supported by

HRSA

- Prostate cancer examinations, screenings, and laboratory work for diagnosis. This will follow the most recent published guidelines of the American Cancer Society.
- Routine immunizations for children, adolescents, and adults who have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention

The complete list of federally required preventive services can be found at the federal Health Insurance Marketplace website at:

https://www.healthcare.gov/coverage/preventive-care-benefits

Primary care office visits

We cover office visits for primary care and/or to treat an injury or illness.

Radiation therapy — outpatient

We cover radiation oncology treatment received as an outpatient at a **hospital** or other **facility**. **Covered health services** include **facility** charges and charges for related supplies and equipment and **physician** services related to **covered health services**.

Rehabilitation services

Medically necessary services for rehabilitation, including speech, language, occupational, and physical therapy must be ordered by a physician and given by suitably licensed medical personnel. We will decide if the service is covered by reviewing both the skilled nature of the service and the need for physician management. We cover semi-private room and board, services, and supplies given during an inpatient stay in an **inpatient rehabilitation facility**. **Rehabilitation services** may also be provided on an outpatient basis.

Covered health services also include chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods to restore or improve motion, reduce pain, and improve function. This applies when a **network** chiropractor finds that the services are **medically necessary** to treat or diagnose neuromusculoskeletal disorders on an outpatient basis.

The following are specifically excluded from chiropractic care and osteopathic services:

- Charges for care not given in an office setting
- Infusion therapy or chelation therapy
- Services of a chiropractor or osteopath that are not within their scope of practice, as

defined by state law

- Maintenance or preventive treatment consisting of routine, long-term, or not **medically necessary** care given to prevent reoccurrences or to maintain the patient's current status
- Manipulation under anesthesia
- Vitamin or supplement therapy

Please see the **Schedule of Benefits** for more information and any limits.

Skilled nursing facility services

We will cover **facility** and professional services in a **skilled nursing facility** when found to be **medically necessary**. We cover **skilled nursing facility** admissions when:

- **Covered services** do not include custodial, domiciliary care, or long-term care admissions.
- **Covered services** are of a temporary nature and supported by a treatment plan.
- The admission is ordered by the **covered person's** attending **physician**. We need written confirmation from the **physician** that skilled care is needed.
- The **skilled nursing facility** is a **network provider.**

These services are limited to 60 days per **benefit period**

Specialist visits

We cover office visits for specialty care services, such as dermatologist and podiatrist visits.

Telemedicine services

Telemedicine services through **First Choice Next Telemedicine** are covered at $0 cost share if you receive services via telemedicine through an **in-network provider** that currently offers the service via telemedicine. Certain specialty services including pediatrics are not eligible for **First Choice Next Telemedicine**. **Telemedicine services** from any other professional **provider** are covered, subject to the same cost-sharing and out-of-network limits as the same health care services when given to a **member** in person. You can check with your **provider** to see if **telemedicine services** are available.

Transplant services

We will cover organ and tissue transplants when ordered by a **physician**, approved through prior authorization, and when the transplant meets the definition of a **covered health service** (and is not an experimental, investigational, or unproven service). We may

need the transplant services provided at a **Center of Excellence facility**. Covered transplant services include services related to donor search and acceptability testing of potential live donors. When the recipient is a **member** under this **policy**, both the recipient and the donor are entitled to **covered health services**, including services reasonably related to the organ removal. We do not cover organ donor expenses for a recipient other than a **member** enrolled on the same family policy. Reasonable costs for travel and lodging may be reimbursed for a covered transplant based on our guidelines. You can ask for these guidelines from us.

Urgent care services

Covered health services include **medically necessary** services by a **network provider**, including approved facility costs and supplies. Your preventive **health care services benefits** with $0 **cost-sharing** may not be used at an urgent care center. You should first contact your PCP for an office visit before seeking care from another **network provider**, but you can use an **in-network** urgent care center when a visit with your PCP is not available.

Exclusions and Limits

Covered health services must be given by a **network provider** unless you get prior authorization for **out-of-network** services. For a benefit to be paid, the **covered health services** must be **medically necessary** for diagnosis or treatment of an illness or injury or be covered under the preventive **health care services** section of this **policy**.

This **health benefit plan** does not cover:

- Any care that extends beyond traditional medical management or **medically necessary** inpatient confinements for conditions such as learning disabilities, behavioral problems, or intellectual disabilities. Examples of care that extends beyond medical management include, but are not limited to:
  - Educational services, such as remedial education that includes tutorial services or academic skills training
  - Neuropsychological testing, such as educational testing that includes I.Q. tests, mental ability, and aptitude tests, unless these tests are for an evaluation for medical treatment
  - Services to treat learning disabilities, behavioral problems, or intellectual disabilities
- Accidental dental services related to injury from biting or chewing
- Ambulance services mainly provided for a ride to and from the physician's office or dialysis center, a ride for receiving a non-covered health service, or the convenience of travel
- Any **covered health service**, supply, or device that would otherwise be at no cost in the absence of coverage by this **policy**
- Any experimental or investigational treatments or unproven services
- Any items or services for personal hygiene or convenience, whether or not they are recommended by a **network provider** or **out-of-network provider,** such as air conditions, humidifiers, physical fitness equipment, stair glides, elevators/lifts, or barrier-free home modifications
- Any medical and/or recreational use of cannabis or marijuana
- Any prescription or over-the-counter drugs not in the **formulary,** unless an exception is granted
- Any prescription vitamins, except vitamins prescribed during **pregnancy**, and fluoride vitamins, or as indicated as covered in the **formulary**

- Any services not identified as a **covered health service** under this **policy**. You will be responsible for full payment for any services that are not **covered health services.**
- Any services, supplies, or prescription drugs to treat sexual dysfunction
- Bariatric surgery, including removal of excess skin from the arms, thighs, and abdomen
- Care given by a family member or person living with you
- Expenses, fees, taxes, or surcharges imposed by a provider or facility that are actually the responsibility of the provider or facility

The following are not covered under your **policy's** prosthetic and **orthotic** device benefit:

- Cosmetic improvements, for example:
  - Implants of hair follicles
  - Skin tone enhancements
- Dental appliances, unless ordered for sleep apnea
- Lenses for keratoconus or any other eye procedures, unless specifically covered under your **policy**

The following **durable medical equipment** services or items are not covered under your **policy**:

- Accessories or appliances that do not serve a medical purpose or its primary use is for comfort or convenience
- Replacement or repair of equipment due to desire for new equipment or due to abuse

The following **rehabilitation services** are not covered under your **policy**:

- Activity or recreational therapy
- All types of special education and supplies or equipment
- Applied behavior analysis therapy, unless for treatment of autism spectrum disorder covered under this **policy**
- Cognitive therapy
- Group classes for pulmonary rehabilitation
- Maintenance therapy

- Massage therapy
- Music therapy
- Remedial reading

The following transplant services are not covered under your policy:

- Animal or artificial tissues or organs transplant services
- Experimental or investigational transplants, including high-dose chemotherapy
- The procurement of tissues, bone marrow, organs, or peripheral blood stem cells, or any other donor services for recipients who are not a member of this **policy**
- The purchase price of organs or tissue if any organ or tissue is sold rather than donated to the recipient member

- Diagnosis and treatment of jaw joint problems including, but not limited to:
  - Crowns or bridges
  - Dental implants or root canals
  - Extractions
  - Orthodontic braces
  - Occlusal (bite adjustments)
  - Treatment of periodontal disease
  - Treatment of **temporomandibular joint disorders**
- Hearing aids
- Infertility services
- Long-term or custodial nursing home care
- Maternity **benefits** for **dependent** children
- Laboratory tests that are not ordered by a **physician** or other provider
- Pulmonary rehabilitation unless provided in conjunction with a lung transplant
- The following habilitative services:
  - Cognitive therapy
  - Group classes for pulmonary rehabilitation

- The following are not covered under this **policy's hospice** benefit:
  - Care not prescribed in the approved treatment plan
  - Financial, legal, or estate planning
  - Homemaker services such as housekeeping, food and meal preparation, and cooking
  - Private-duty nursing
  - Respite care
- The following are not covered for at-home treatment or care under this **policy's home health care** benefit:
  - Care not prescribed in the approved treatment plan
  - Chemotherapy and radiation therapy
  - Chronic condition care
  - Dietary care
  - Disposable supplies
  - **Durable medical equipment**
  - Homemaker services such as housekeeping, food and meal preparation, and cooking
  - Imaging services
  - Inhalation therapy
  - Laboratory tests
  - Prescription drugs, except home infusion services
  - Volunteer care
- The following are not covered under your chiropractic and osteopathic benefit:
  - Any charges for care received outside of an office visit setting
  - Chelation therapy
  - Infusion therapy
- The following **skilled nursing facility** services are not covered under your policy:
  - Convalescent care
  - Custodial care

  - Domiciliary care
  - Intermediate, rest, or homelike care
  - Long-term care admissions
  - Protective and supportive care
- Treatment received outside the United States, except for a medical **emergency** while traveling in accordance with the **emergency services** section of this **policy**

In no event will **benefits** be provided for **covered health services** under the following circumstances:

- For abortion, unless needed to save the life or health of the **member**, or as a result of incest or rape
- For **behavioral health** services related to:
  - Court-ordered services needed for parole or probation
  - Marital and relationship counseling
  - Testing for aptitude or intelligence
  - Testing for evaluation and diagnosis of learning abilities
- For cosmetic procedures, other than reconstructive surgery related to a surgery or injury covered under this **policy** or for correction of a birth defect in a child
- For dental services except accidental injuries. We will inform adult **members** of the availabilities of standalone pediatric dental plans when they choose and enroll in a plan.
- Any examinations, tests, or screenings for employment
- For expenses related to television, phone, or expenses for other persons
- For fetal reduction surgery
- For nontraditional alternative or complementary medicine not consistent with conventional medicine. These include, but are not limited to, acupuncture, hydrotherapy, hypnotism, and alternative treatment modalities including, but not limited to, boot camp, equine therapy, wilderness therapy, and similar programs.
- For services related to surrogate parenting
- For standby availability of a medical **provider** when no treatment is provided
- For the reversal of sterilization or vasectomies
- For treatment of injuries sustained while participating in organized collegiate sports, professional or semiprofessional sports, or other recreational activities for which the **subscriber** and/or **dependent** is paid to participate
- Services or supplies given before the **effective date** or after the termination date of

this **policy**, except as noted under the Eligibility and Termination sections of this **policy**

GRIEVANCES AND APPEALS

Sometimes First Choice Next may decide to deny or limit a request your **provider** makes for you for benefits or services offered by our plan. To keep you satisfied, we offer ways to file a **grievance** or **appeal**. You have the right to file a **grievance**, file an appeal, and to an external review with respect to certain **Adverse Benefit Determinations** or **appeals** not decided in your favor.

When First Choice Next receives an initial **complaint**, we will respond within a reasonable time after submission. At the time of initial receipt of your **complaint,** we will inform you of your right to file a **grievance** at any time. We can help you do so.

Our **grievances** and **appeals** processes are in place to address concerns you may have with a service issue, quality of care, or the denial of a claim or request for service. In general, any concern about the quality of care or service is considered a **grievance**. Concerns about the denial of a claim or request for service are considered **appeals**. Our **grievance** process is available for review of any **policy**, decision, or action we make that affects the **member**.

If you need help with filing a **grievance** or **appeal**, we will help walk you through the process. This includes help with completing forms, providing interpreter and translation services, or providing TTY support and ancillary aid. Additionally, free letter translations are available on request. This service is provided to you at no charge by calling Member Services at 1-833-983-7272 (TTY 711).

Grievances

You, your **authorized representative**, or your **provider** can file a **grievance** with us at any time. You can do so in writing or over the phone. **Grievances** must be submitted within one year after the date of occurrence of the action that initiated the **grievance**. The **Grievance** process is voluntary.

A **grievance** should be provided to us by you or your **authorized representative** by phone at 1-833-983-7272 or in writing at:

Member Grievances

PO BOX 7202

London, KY 40742-7202

On filing your **grievance**, please include any information you believe supports your case. We will carefully consider the issue(s) you raise, and we will never charge you anything to file a **grievance**. Filing a **grievance** will also never affect your **benefits**.

Once we have received your **grievance**, we will send you written acknowledgement within 90 days of receipt of your grievance. A written **complaint** submitted by a **member** about

a decision rendered solely on the basis that the **health benefit plan** contains a **benefits** exclusion for the health care service in question is not a **grievance** if the exclusion of the specific service requested is clearly stated in this **policy**.

After we research your concern, we will send you and, if applicable, your **authorized representative** a written notice on how your concern has been resolved. We will provide you with this written notice within 90 calendar days of receiving your **grievance**.

If our decision is not in your favor, the written notice will have:

- The qualifications of the person or persons who reviewed your **grievance**.
- A statement from the reviewers summarizing the **grievance**.
- The reviewers' decision in clear terms and the basis for the decision.
- A reference to any documentation used as a basis for the decision.

The South Carolina Department of Insurance is available to help insurance consumers with insurance related problems and questions. You may ask in writing to the Department at:

Consumer Services Division

P.O. Box 100105

Columbia, SC 29202-3105

Phone: 1 (803) 737-6180 or 1 (800) 768-3467

Fax: 803-737-6231

Email: consumers@doi.sc.gov

Online complaint form: https://doi.sc.gov/consumers

At any time, you can request free copies of all records and other information we have relevant to your written **grievance**, including the name of any **health care professional** we consulted. For copies, please call **Member** Services at 1-833-983-7272.

Standard appeals

You or your **authorized representative** can file an **appeal** of an **Adverse Benefit Determination** verbally by calling **Member** Services at 1-833-983-7272 or in writing to Address to be added.

An **appeal** must be filed within 180 days from the date of our written notice denying your claim or your request for service. The **appeal** procedure is voluntary for the **member**. An **appeal** may be initiated and/or proposed by the **member** or authorized representative,

including their **provider**. We will also help you with filing the written **appeal** if you need it.

Verbal **appeals**: The date you make your verbal **appeal** counts as the date of receipt of your **appeal**.

Once your **appeal** is received, we will start researching your **appeal**. Within five business days after receiving a request for a standard, non-expedited **appeal**, we will provide you with the name, address, and phone number of the coordinator and information on how to submit written material. You or your **authorized representative** will be allowed to access any medical records or other documents we have that relate to the subject of the **appeal** at no cost to you. You can ask for these records and documents by calling Member Services at 1-833-983-7272, 8 a.m. – 8 p.m., 5 days a week. If your review needed **physician** review, the **physician** reviewing your **appeal** will:

- Not have been involved in the previous decision on your claim or request for service
- Have the suitable training in your condition or disease
- Not be a subordinate of any person involved in the initial decision to deny services

You have the right to request that the health care provider performing the review of your appeal practices in the same specialty as your attending physician. You can provide evidence to support your **appeal** by phone, in writing, or in person. Once we have made a decision on your **appeal**, we will send you written notice of the decision within 30 calendar days for pre-service and post-service **appeals.** If the request is an accepted expedited appeal, we will instead decide within 72 hours of the request receipt. In rare circumstances the 30 day decision timeframe may be extended up to 60 days. If your **appeal** concerns continuation of a service that you are currently receiving, you can continue getting the services being appealed either until the end of the approved treatment period or until the decision of the **appeal**.

You may be financially responsible for the continued services if the **appeal** is not approved. You can ask for continued services by calling **Member** Services at 1-833-983-7272 (TTY 711). Note: You cannot request an extension of services after the original authorization has ended. To learn more, please call **Member** Services.

Expedited appeals

An expedited **appeal** can be requested by you or your **authorized representative** either verbally or in writing. An expedited **appeal** must be filed within 180 days from the date of our written notice denying your claim or your request for service. An expedited **appeal**

will be made available when a non-expedited **appeal** would reasonably appear to seriously jeopardize the life or health of a **covered person** or jeopardize the **covered person's** 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 cannot be adequately managed without the requested care or treatment. Your **provider** can also file a verbal request for expedited **appeal**. We will not need written follow-up for a verbal request for expedited **appeal**. We may need documentation of the medical justification for an expedited **appeal**.

We will assign your request for expedited **appeal** to a **clinical peer**. You will have the chance to provide evidence to support your **appeal** by phone, in writing, or in person. When we have made a decision on your **appeal**, we will notify you verbally of our decision within 72 hours of receiving the expedited **appeal** request or within 2 business days of receipt of all necessary information to complete the appeal.

If we deny the request for the **appeal** to be processed in an expedited manner, we will handle the request as a standard **appeal** and will send written notice to you or your **authorized representative** that we have denied your request for an expedited **appeal**. You have the right to submit a **grievance** if the expedited **appeal** is handled as a standard **appeal**.

We will, in consultation with a doctor, provide expedited review and communicate the decision to covered **members** and their **providers** as soon as possible. If the expedited review is a concurrent review decision, we will remain liable for the coverage of **health care services** until the **covered person** has been notified of the decision. We do not need to provide an expedited review for retrospective **Adverse Benefit Determinations**.

You or your **authorized representative** may access any medical records or other documents we have that relate to the subject of the expedited **appeal** at no cost to you. You have the right to request that the health care provider performing the review of your appeal practices in the same specialty as your attending physician. The **physician** reviewing your **appeal** will:

- Not have been involved in the previous decision on your claim or request for service
- Have suitable training in your condition or disease
- Not be a subordinate of any person involved in the initial decision to deny services

Independent External Review Procedure

South Carolina law makes available to you an independent external review of **Adverse**

Benefit Determination decisions made by First Choice Next at no cost to you. The external review will be performed by a third-party Independent Review Organization (IRO) that has clinical expertise and is not associated with First Choice Next. This service is provided to you at no charge. External review is done on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review. We will notify you in writing of your right to ask for an external review each time you:

- Receive an **Adverse Benefit Determination** decision
- Receive an **appeal** decision upholding an **Adverse Benefit Determination** decision, also known as a **Final Determination**

When processing your request for external review, we will need you to provide a written, signed authorization for the release of any of your medical records that may need to be reviewed for reaching a decision on the external review.

Exhaustion of internal appeals

A request for external review may not be made until the covered person has exhausted our internal appeal process. You will be considered to have exhausted the internal review process if:

- You completed our **appeal** process and received a written determination from us; or
- You received notification that we have agreed to waive the exhaustion requirement; or
- We did not issue a written decision within the time frames outlined in the expedited and standard appeals section of this **policy** after receiving all information needed to complete the appeal, unless you or your authorized representative agreed to a delay; or
- You submit an expedited external review request at the same time as an expedited internal appeal with us.

Eligibility for independent external review

For your request to be eligible for external review:

- Your coverage with us must be in effect when the **Adverse Benefit Determination** decision was issued;
- The service for which the **Adverse Benefit Determination** was issued appears to be a covered service under your **policy**; and

- You have exhausted our internal review process as described below unless you submit an expedited external review request at the same time as an expedited internal appeal with us.
- Your request must be a consideration of whether First Choice Next is complying with the surprise billing and **cost-sharing** protections under the Public Health Service Act or be a determination that resulted in an **Adverse Benefit Determination** decision for reasons of:
    - **Medical necessity**, suitability, health care setting, level of care or effectiveness of health services, or the treatment that you are requesting is experimental or investigational; or
    - A rescission in coverage.

If your request for a standard external review is related to a retrospective **Adverse Benefit Determination** (an **Adverse Benefit Determination** that occurs after you have received the services in question), you will not be eligible to ask for a standard review until you have completed our internal review process and receive a written **Final Determination** notice. An expedited external review is not available for retrospective **Adverse Benefit Determinations**.

If the denial for coverage is based on a decision that the health care service or treatment recommended or requested is experimental or investigational, the request for review must include a certification from your treating physician. This physician must be a licensed physician qualified to practice in the area of medicine to treat your condition. Your treating physician must certify that you meet all of the following:

- You have a life-threatening disease or seriously disabling condition; and
- At least one of the following situations applies:
    - Standard health care services or treatments have not been effective in improving your condition
    - Standard health care services or treatments are not medically suitable for you
    - The recommended or requested service or treatment is more beneficial than the standard health care service or treatment covered by your **policy**; and
- Medical and scientific evidence using accepted protocols demonstrate that the health care service or treatment you requested is more beneficial to you than available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be

substantially increased over those of the standard services or treatments

Standard external review requests

Your request for standard external review must be submitted in writing to First Choice Next within four months of receiving our notice of **final determination** that the services in question are not approved. You can submit this request to First Choice Next at PO BOX 7330, London, KY 40742-7330 or fax the request to 1-833-329-8686.

Expedited external review requests

An expedited external review of an **Adverse Benefit Determination** decision may be available if:

- Your treating physician certifies that you have a serious medical condition where the time needed to complete either an expedited internal **appeal** or a standard external review would reasonably be expected to seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or
- Your request for external review concerns an admission, availability of care, continued stay, or health care service for which you received emergency care as defined by state law, but have not been discharged from the facility.

There is no time limit for expedited external review requests. They can be submitted in writing to PO BOX 7330, London, KY 40742-7330 or by fax to 1-833-329-8686.

IRO external review eligibility determination

Within five business days of receipt of your request for a standard external review, and as expeditiously as reasonably possible for expedited external review requests, we will complete a review of your request. This review will decide if you meet the requirements for external review. If you do not meet the criteria for external review, we will notify you, your **provider**, or the authorized representative who submitted the request of our eligibility decision within one business day of our review decision. If a request is made for an expedited external review, we will consult with a medical professional to decide whether your request meets expedited requirements. If your request is not accepted for expedited review, we may either:

- Accept the case for standard external review if our internal **appeal** process was already completed, or
- Need the completion of our internal **appeal** process before you may make another request for an external review.

If you are dissatisfied with our decision, you may call the South Carolina Department of

Insurance for more help.

IRO assignment

If your request for external review is accepted, we will send your request to the South Carolina Department of Insurance (SC DOI) and inform them of your need for assignment of an IRO. The SC DOI will assign an IRO to review your request on an independent, impartial, rotational system. We will in no way influence the choice of IROs or the decision of the IRO reviewers. We will verify there is no conflict of interest with the assigned IRO. If there is a conflict of interest, we will notify the SC DOI and request assignment of another IRO.

We need to send all documents and any information considered in making the **Adverse Benefit Determination** or **Final Determination** to the IRO within five business days of receipt of your request for standard external review and as expeditiously as possible (not to exceed 72 hours) for expedited external review requests. If we do not provide all pertinent information to the IRO within this time frame, it will not delay the conduct of your external review. The IRO may then end the external review and make a decision to reverse the **Adverse Benefit Determination** or **Final Determination**. If this occurs, the IRO will contact us and you or your authorized representative right away.

For standard review requests, within five business days from receipt of the request, the IRO will provide written notice to the requestor of the request eligibility and acceptance for external review. If the request is incomplete the notice will explain what information is needed to complete the request. The notice will also include the right to submit more information that relates to the case. Any more information provided to the IRO will be shared with us so we may reconsider our initial decision. The external review will be ended if we decide to reverse our decision and approve your request based on the information provided.

IRO review and decision

The IRO will send the requestor written notice of its determination within 45 calendar days for standard external review requests from the IRO’s date of request receipt. Expedited review request decisions will be communicated within 72 hours from the date we received the initial request. Decisions can be communicated verbally or in writing. If the decision is communicated verbally, the IRO will send written notice after verbal notification within the suitable regulatory time frame.

If the IRO's decision is to reverse the **Adverse Benefit Determination**, we will reverse the **Adverse Benefit Determination** decision. We will approve the covered benefit or supply that was the subject of the **Adverse Benefit Determination** within five business days of

receiving notice of the IRO's decision for standard external review requests, and as expeditious as reasonably possible for expedited external review requests. If you are no longer covered by us at the time we receive notice of the IRO's decision to reverse the **Adverse Benefit Determination**, we will only provide coverage for those services or supplies you actually received or would have received before **disenrollment** if the service had not been denied when first requested.

The IRO's external review decision is binding on us and you, except to the extent you may have other remedies under applicable federal or state law. If such other remedies are available, the **covered person** or their **authorized representative** may not, in these proceedings, use, disclose, or introduce in evidence information generated during or findings reached by the IRO. You may not file a subsequent request for an external review involving the same **Adverse Benefit Determination** decision for which you have already received an external review decision.

If at any time you are dissatisfied with the external review process, need assistance, or have questions about your member rights, you can contact the Director or his designee of the SC DOI at:

Consumer Services Division

P.O. Box 100105

Columbia, SC 29202-3105

Phone: 1 (803) 737-6180 or 1 (800) 768-3467

Fax: 803-737-6231

consumers@doi.sc.gov

Online complaint form: https://doi.sc.gov/consumers

Claims and Reimbursement

Claims

First Choice Next is not liable under this policy unless proper notice is given to us by you or someone authorized to act on your behalf that covered services have been given to a member.

Network provider claims

The **network provider** is responsible for filing all claims in a timely manner. You will not be responsible for any claim that is not filed on a timely basis by a **network provider**. If you provide your insurance card to a **network provider** at the time of service, the **provider** will bill us directly for claims you have. If covered, we will reimburse your **provider** directly. Claims will be paid in accordance with state law.

Out-of-network provider claims

For **out-of-network** services to be covered, **prior authorization** must be obtained before the service being given unless described elsewhere in this document. You or your **provider** need to give notice of any claim for services given by an **out-of-network provider**. No payment will be made for any claims filed by a **member** for services rendered by **an out-of-network provider** unless you give written notice of such a claim to First Choice Next within 180 days of the date of service. Failure to submit a claim within the time needed does not invalidate or reduce any claim if it was not reasonably possible for you to file the claim within that time. This will apply provided the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the **member**, later than one year from the time submittal of the claim is otherwise needed.

Notice of claim

Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice may be given to First Choice Next at our home office or our agent. Notice should include the name of the insured and the policy number. If you have a disability for which benefits may be payable for at least two years, at least once every six months after you have given notice of claim, you shall give First Choice Next notice that the disability has continued. You need not do this if legally incapacitated. The first six months after any filing of proof by you or any payment or denial of a claim by First Choice Next will not be counted in applying this provision. If you delay in giving this notice, your right to any benefits for the six months before the date when you give notice will not be impaired.

To get a claim form for giving notice of a claim, please call us at the phone number listed

on your member ID card. You must sign the claim form before we will issue payment to a provider or reimburse you for covered services received under this policy. You must complete a claim form for services given by an out-of-network provider and submit it, together with an itemized bill and proof of payment, to First Choice Next, 200 Stevens Drive, Philadelphia, PA 19113.

Reimbursement

Reimbursement will be made only for covered services received in accordance with the provisions of this **policy**. If you need to make payment other than a needed **copayment**, **deductible**, or **coinsurance** amount at the time covered services are given, we will ask that your **provider** reimburse you, or we will reimburse you by check.

Claim forms

When we receive the notice of claim, we will direct you to where you can access a claim form for filing a proof of loss or send you a claim form by mail if you ask for it. If these forms are not given to you within 15 days, you will meet the proof of loss requirements by giving First Choice Next a written statement of the nature and extent of the loss within the time limits stated in the Proofs of Loss section.

All claims submitted by your **provider** will be submitted on a uniform form or format. This form or format shall be developed by the **Department** and approved by the **Commissioner**, whether submitted in writing or electronically.

Proofs of loss

Written proof of loss must be given to First Choice Next for which this policy provides any periodic payment, dependent on continuing loss within 90 days after the end of each period for which the First Choice Next is liable. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time needed, First Choice Next may not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. The needed proof must be given no later than one year from the time specified unless the claimant was legally incapacitated.

Time of payment of claims

After receiving a claim form and written proof of loss, we will pay monthly all benefits then due for the term of this **policy**. We will direct the issuance of a check or an electronic funds transfer in payment for a clean claim that is submitted via paper within 40 business days, and within 20 business days for a clean claim that is submitted electronically, following the later of First Choice Next's receipt of the claim or the date on which First Choice Next is in receipt of all information needed and in a format required for the claim to constitute a clean claim and is in receipt of all documentation which may be requested by an insurer which is reasonably needed by us:

- To determine that such claim does not contain any material defect, error, or impropriety; or
- To make a payment determination.

Payment of claims

Benefits will be paid to the insured. Loss of life benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the **benefits** will be paid to the insured's estate. Any other **benefits** unpaid at death may be paid, at the company's option, either to the insured's beneficiary or estate.

If **benefits** are payable to the insured's estate or a beneficiary who cannot execute a valid release, the company can pay benefits up to one thousand dollars to someone related to the insured or beneficiary by blood or marriage whom the company considers to be entitled to the **benefits**. First Choice Next will be discharged to the extent of any such payment made in good faith.

First Choice Next may pay all or a portion of any indemnities provided for health care services to the provider, unless the insured directs otherwise in writing by the time proofs of loss are filed. First Choice Next cannot require that the services be rendered by a particular provider.

Unpaid premium

At the time of payment of a claim under this plan, any premium then due and unpaid may be deducted from the claim payment**.**

Member Rights and Responsibilities

Member rights

A **member** has the right to:

- Get information about the health plan, its **benefits**, services included or excluded from coverage policies, and **network providers'** and **members'** rights and responsibilities. Written and web-based information given to the **member** must be readable and easily understood.
- Be treated with respect and be recognized for their dignity and right to privacy.
- Participate in decision-making with **providers** about their health care. This right includes candid discussions of suitable or **medically necessary** treatment options for their condition, regardless of cost or **benefits** coverage.
- Voice **grievances** or **appeals** about the health plan or care provided and receive a timely response. The **member** has a right to be notified of the disposition of **appeals** or **grievances** and the right to further **appeal**, as suitable.
- Make recommendations about our **member** rights and responsibilities policies by contacting Member Services.
- Choose **providers**, within the limits of the **provider network**, including the right to refuse care from specific **providers**.
- Have confidential treatment of personally identifiable health or medical information. The **member** also has the right to have access to their medical record per applicable federal and state laws.
- Be given reasonable access to medical services.
- Receive **health care services** without discrimination based on race; color; religion; sex; age; national origin; ancestry; nationality; citizenship; alienage; marital, domestic partnership, or civil union status; affectional or sexual orientation; physical ability; pregnancy (including childbirth, lactation, and related medical conditions); cognitive, sensory, or mental disability; human immunodeficiency virus (HIV) status; military or veteran status; whistleblower status (when applicable under federal or state law depending on the locality and circumstances); gender identity and/ or expression; genetic information (including the refusal to submit to genetic testing); or any other category protected by federal, state, or local laws.
- Formulate advance directives. The plan will provide information about advance directives to **members** and **providers**. The plan will also support **members** through

our medical record-keeping policies.

- Get a current directory of **network providers** on request. The directory includes addresses, phone numbers, and a listing of **providers** who speak languages other than English.
- File a **complaint** or **appeal** about the health plan or care provided with the applicable regulatory agency and receive an answer from the **health benefit plan** to those **complaints** within a reasonable period of time.
- **Appeal** a decision to deny or limit coverage through an independent organization. The **member** also has the right to know that their **provider** cannot be penalized for filing a **complaint** or **appeal** on the **member's** behalf.
- **Members** with chronic disabilities have the right to get help and referrals to **providers** who are experienced in treating their disabilities.
- Have candid discussions of suitable or **medically necessary** treatment options for their condition, regardless of cost or **benefits** coverage, in terms that the **member** understands. This includes an explanation of their medical condition, recommended treatment, risks of treatment, expected results, and reasonable medical alternatives. If the **member** is unable to easily understand this information, they have the right to have an explanation provided to their designated representative and documented in the **member's** medical record. The plan does not direct **providers** to restrict information regarding treatment options.
- Have available and accessible services when **medically necessary**, including availability of care 24 hours a day, seven days a week, for urgent and **emergency** medical conditions.
- Call 911 in a potentially life-threatening situation without prior approval from the plan. A member has the right to have the plan pay per contract for a medical screening in the **emergency** room to find whether an **emergency medical condition** exists.
- Continue getting services from a **provider** who has been terminated from the plan's **network** (without cause) in the time frames as outlined. This continuity of care allowance does not apply if the **provider** is terminated for reasons that would endanger the **member**, public health, or safety, or that relate to a breach of contract or fraud.
- Have the rights afforded to **members** by law or regulation as a patient in a licensed health care **facility**, including the right to refuse medication and treatment after

possible results of this decision have been explained in language the **member** understands.

- Receive prompt notice of terminations or changes in **benefits**, services, or the **provider network**.
- Have a choice of specialists among **network providers** after an authorization or referral as applicable, subject to their availability to accept new patients.
- Any person purchasing an individual accident, health, or accident and health insurance policy after July 1, 1991, shall have the right to transfer to any individual policy of equal or lesser benefits offered for sale by the insurer at the time the transfer is sought.

Member responsibilities

A **member** has the responsibility to:

- Let the plan and **network providers** know, to the extent possible, information that they need to care for the member.
- Follow the plans and instructions for care that they have agreed on with their **providers**. This responsibility includes considering the possible results of failure to follow the recommended treatment.
- Understand their health problems and participate in creating mutually agreed-on treatment goals as much as possible.
- Review all **benefits** and membership materials carefully and follow health plan rules.
- Ask questions for their understanding of any explanations and instructions.
- Treat others with the same respect and courtesy they expect to receive.
- Keep scheduled **provider** visits or give adequate notice of delay or cancellation.

GENERAL PROVISIONS

Entire policy

This **policy**, including an application for coverage and any enrollment forms, amendments, **riders**, and endorsements, and a **Schedule of Benefits**, if any, constitutes the exclusive and entire contract of insurance between you and the health plan, and shall be binding on all **covered persons**; the health plan; and any of our subsidiaries, affiliates, successors, heirs, and permitted assignees. All prior negotiations, agreements, and understandings are superseded hereby. No oral statements, representations, or understanding by any person can change, alter, delete, add to, or otherwise modify the express written terms of this contract. There are no warranties, representations, or other agreements between you and us in connection with the subject matter of this plan, except as specifically set forth herein.

Modifications

This contract may not be modified, amended, or changed, except in writing and signed by an officer of First Choice Next or the person designated by an officer of First Choice Next. No employee, agent, or other person is authorized to interpret, amend, modify, waive, or otherwise change this contract or any of its provisions. Notwithstanding the foregoing, we have the right to and may modify or otherwise change the terms and conditions of the contract to make periodic administrative modifications. We will notify you in writing of any changes to this contract.

Time limit on certain defenses

After two years from the issue date of this **policy,** only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability that starts after the two-year period.

Non-waiver

If we or you fail to enforce or to insist on strict compliance with any of the terms, conditions, limits, or exclusions of the **policy**, that will not be considered a waiver of any rights under the **policy**. A past failure to strictly enforce the **policy** will not be a waiver of any rights in the future, even in the same situation or set of facts.

Conformity with state laws

Any term of this **policy**, which on its effective date, is in conflict with South Carolina law or with any applicable federal law that imposes additional requirements beyond what is needed under South Carolina law will be amended to conform with the minimum requirements of such law.

Nondiscrimination

First Choice Next does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, genetic information, or health status in the administration of the plan, including enrollment functions and benefit determinations. race; color; religion; sex; age; national origin; ancestry; nationality; citizenship; alienage; marital, domestic partnership, or civil union status; affectional or sexual orientation; physical ability; pregnancy (including childbirth, lactation, and related medical conditions); cognitive, sensory, or mental disability; HIV status; military or veteran status; whistleblower status (when applicable under federal or state law depending on the locality and circumstances); gender identity and/ or expression; genetic information (including the refusal to submit to genetic testing); or any other category protected by federal, state, or local laws.

Continuation of benefit limits

Some of the **benefits** in this **policy** may be limited to a specific number of visits and/or subject to a **deductible**. You will not be entitled to any more **benefits** if your coverage status should change during the year. All **benefits** used under your previous coverage status will be applied toward your new coverage status.

Protected health information (PHI)

Your health information is personal. We are committed to doing everything we can to protect it. Your privacy is also important to us. We have policies and procedures in place to protect your health records.

We protect all oral, written, and electronic PHI. We follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. We need to notify you about these practices every year. Our Notice of Privacy Practices describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. If you have questions or would like the full notice, visit https://www.firstchoicenext.com/about/contact.aspx. Or you can call Member Services at 1-833-983-7272.

Our relationship with providers

Network providers are not our agents or employees. We do not provide **health care services** or supplies. We also do not practice medicine. Instead, we arrange for **health care providers** to participate in our **network**, and we pay **benefits**. **Network providers** are independent **providers** who run their own offices and facilities. We are not liable for any act or omission of any **provider**.

Legal actions

No legal action may be brought to recover on this **policy** within 60 days after written proof of loss has been given as needed by this **policy**. No such action may be brought after six years from the time written proof of loss is required to be given.

Conformity with state statutes

Any provision of this policy that, on its effective date, is in conflict with the laws of the state in which the insured resides on that date is amended to conform to the minimum requirements of such laws**.**

Misstatement of age

If the insured's age has been misstated, the benefits will be those the premium paid would have purchased at the correct age.

Physical examinations and autopsy

First Choice Next at its own expense may have the insured examined as often as reasonably necessary while a claim is pending. In cases of death of the insured, First Choice Next at its own expense also may have an autopsy performed during the period of contestability unless prohibited by law. The autopsy must be performed in South Carolina.

Insurance with other insurers

If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision-of-service basis or on an expense-incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense-incurred coverage of this policy shall be for such proportion of the loss as the amount that would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision-of-service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

Insurance with other insurers, other benefits

If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense-incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such

benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss and for the return of such portion of the premium paid as shall exceed the pro ratio portion for the indemnities thus determined.

Coordination of benefits

This **policy** does not coordinate benefits with any other policies. That means that this **policy** pays benefits regardless of other coverage you might have.

Subrogation

In a case where a health insurer has a legal liability to make payments for medical assistance to or on behalf of a person, to the extent that payment has been made under a State Plan for Medical Assistance pursuant to Title XIX of the Social Security Act for health care items or services furnished to the person, the State is considered to have acquired the rights of the person to the payment for the health care items or services. To the extent that benefits for **covered health services** are provided or paid under this **policy**, the plan shall be subrogated and succeed to any rights of recovery of a **member** as permitted by law for expenses incurred against any person, firm, corporation, business entity, or organization except insurers on policies or health insurance issued to and in the name of the **member**. The **member** shall execute and deliver such instruments and take such other reasonable action as the plan may need to secure such rights, as permitted by law. The **member** shall do nothing to prejudice the rights given the plan by this paragraph without its consent. These provisions shall not apply where subrogation is specifically prohibited by law.

Congenital defects and anomalies

First Choice Next provides the same **benefits** for covered minor children with congenital defects or anomalies as any other sickness or illness the minor child may have.

Pre-existing conditions

First Choice Next does not exclude coverage based on pre-existing conditions.

Lifetime and annual dollar limits

First Choice Next does not apply lifetime or annual dollar limits to any of the **benefits** in your **policy.**

Preventive and wellness services and chronic disease management

First Choice Next complies with the recommendations set forth by the National

Prevention, Health Promotion and Public Health Council.

Third party payor

First Choice Next accepts premium and cost-sharing payments for **Qualified Health Plans** from the following third-party entities from plan enrollees:

- A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
- An Indian tribe, tribal organization, or urban Indian organization; and
- A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.

Duties of First Choice Next of a child to a custodial parent

If a child **dependent** is covered under a non-custodial parent's **policy**, First Choice Next shall:

- Provide information to the custodial parent as may be necessary for the child to obtain **benefits** through that coverage;
- Permit the custodial parent or the health care provider, with the custodial parent's approval, to submit claims for **covered health services** without the approval of the noncustodial parent; and
- Make payments on claims submitted in accordance with item (2) directly to the custodial parent, the provider, or the state Medicaid agency.

Payment of providers for emergency services

First Choice Next will pay **providers** for emergency medical care services provided to a **covered person** who presents an **emergency medical condition**. This provision does not allow for coverage of illnesses, diseases, equipment, supplies, procedures, or treatments which are not otherwise covered under the terms of this **policy**.First Choice Next will not retrospectively deny or reduce payments to **providers** for emergency medical care of a **covered person** even if it is determined that the **emergency medical condition** initially presented is later identified through screening not to be an actual emergency, except in the these cases:

- Material misrepresentation, fraud, omission, or clerical error;
- A payment reduction is applied due to applicable member cost share responsibilities such as **copayments**, **coinsurance**, or **deductibles**;
- Cases in which the **covered person** does not meet the **emergency medical condition** definition, unless the **covered person** has been referred to the

emergency department by their **primary care provider** or other agent acting on behalf of First Choice Next**.**

Change of beneficiary

The insured can change the beneficiary at any time by giving First Choice Next written notice. The beneficiary's consent is not required for this or any other change in the **policy**, unless the designation of the beneficiary is irrevocable.

HOW TO CONTACT US

Method	Member Services — contact information
Call	1-833-983-7272 Calls to this number are free. Hours of operation: 8 a.m. to 8 p.m., Monday to Friday
TTY	711 Calls to this number are free.
Fax	1-833-726-7329
Write	Mailing address: 200 Stevens Drive, Philadelphia, PA 19113
Website	https://www.firstchoicenext.com/about/contact.aspx

Language help and alternate formats

Help is available at no cost to help **members** communicate with us. The services include, but are not limited to:

- Interpreters for languages other than English.
- Written information in alternative formats, such as large print.
- Help with reading our website.

To ask for help with these services, please call the Member Services number on your member ID card.

Spanish (US):

ATENCIÓN: Si usted habla español, tiene a su disposición servicios de asistencia de idioma gratuitos. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese (S):

注意：**如果您**讲中文，我们可以为您提供免费的语言协助服务。请拨打您ID **卡上的会**员服务电话号码。

Vietnamese:

LƯU Ý: Nếu quý vị nói tiếng Việt, sẽ có dịch vụ hỗ trợ ngôn ngữ miễn phí dành

cho quý vị. Hãy gọi số Dịch vụ Hội viên trên thẻ ID của quý vị.

Korean:

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. ID 카드에 있는 회원 서비스 번호로 전화하십시오.

French (FR):

REMARQUE : si vous parlez français, des services d’assistance linguistique gratuits sont à votre disposition. Appelez le numéro des services aux membres, qui figure sur votre carte d’identification.

Arabic:

تنبيه: إذا كنت تتحدث اللغة العربية، فيمكنك االستعانة بخدمات المساعدة اللغوية بدون مقابل. اتصل برقم خدمات أألعضاء المدون على

بطاقة التعريف الخاصة بك.

Hmong:

UA ZOO SAIB: Yog tias koj hais ib hom lus dhau ntawm lus As Kiv, muaj cov kev pab cuam txhais lus uas tsis xam nqi dab tsi rau koj tau siv. Hu rau Lub Chaw Pab Cuam Tswv Cuab tus nab npawb xov tooj nyob ntawm koj daim npav ID.

Russian:

ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните в Службу работы с клиентами по телефону, указанному в Вашей идентификационной карте.

Tagalog:

PANSININ: Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo para sa wika. Tawagan ang numero ng Mga Serbisyo sa Miyembro na nasa inyong ID kard.

Japanese:

注記：日本語をお話しになる方は、無料の言語アシスタンスサービスをご利用いただけます。IDカード に記載のメンバーサービス電話番号までお電話ください。

German:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie unter der auf Ihrer ID-Karte aufgeführten Telefonnummer für Mitgliederdienstleistungen an.

Gujarti:

ધ્યાન આપો: જો તમે અંગ્ેજી સિવયા્ની અન્ કોઇ ભયાષયા બોલો છો, તો તમયારયા મયાટે ભયાષયા िહયા् िेવયાઓ સનઃશલ પર કોલ કરો. ક ઉપલબ્ધ છે. તમયારયા આઇડી કયાડ્ પર રહલ યા िદસ્ની िेવયાઓનયાં નબર

Hindi:

ध्यान दें: ्दद आप अंग्रेजी करे अलयावया कोई अन् भयाषया बोलतरे हैं, तो आपकरे ललए मुफ़त में भयाषया सहयात्तया सरेवयाएं उपलब्ध हैं। आपकरे आईडी कयाड्ड पर ददए गए सदस् सरेवया नंबर पर कॉल करें।

Laotian:

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາອ່ ນ , ການບໍລິການຊ່ວຍເຫຼືອ ດ້ານພາສາ ່ ບ ່ ນອກຈາກພາສາອງັກ

Mon-Khmer:

ចាប់អារម្មណ៍ ៖ បបសិនបបើបោកអ្នកនិយាយភាសាបប្សេង បបរៅពីភាសាអង់ប្លេស បោះបសរ ជំនួយភាសាបោយឥតគ្ិតថ្លេ ីមានសបមាប់បោកអ្នក។ សូមទូរស័ព្ទបៅបេខបសរាបបបមើ សមាជិកដែេមានបៅបេើកាតសមាគ េ ់រប ស់បោកអ្នក។

Persian Farsi:

برای این منظور . در صورتی که به زبانی غیر از انگلیسی صحبت می کنید خدمات کمکی زبانی به طور رایگان برای شما وجود دارد:توجه
با شماره خدمات اعضای موجود روی کارت شناسایی خود تماس بگیرید

4813-6644-7606, v. 5