2027 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, 2027, 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 25 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.

Guaranteed Renewable

Guaranteed renewable means this **policy** will renew on the policy's anniversary date of 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. Reasons for non-renewal of coverage include but are not limited to loss of eligibility due to no longer residing in the service area, failure to pay required **premiums** timely, a dependent child attaining age 26, acts of fraud, and our discontinuation of

your health benefit plan. This **health plan** is a regulated insurance product. Its **policy** forms, rates, **premiums**, **cost-sharing** arrangements, and other materials are filed each year for approval by the South Carolina Department of Insurance. As such, your **premiums** may increase when you renew. However, we will write to you about any increases at least 31 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 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays.

Select Health of South Carolina, Inc

Loretta Lenko

Loretta Lenko, President – Exchange

TABLE OF CONTENTS

Policy	2
Table of Contents	4
Definitions of Important Words	5
Eligibility and Termination	25
How to Use Your Health Plan	33
Covered Health Services	47
Prescription Drug Benefits	63
Additional Covered Health Services and Programs	78
Exclusions and Limitations	80
Grievances/Complaints and Appeals	87
Claims and Reimbursement	97
Member Rights and Responsibilities	100
General Provisions	103
Appendix A - Coordination of Benefits	109
Appendix B - Coordination of Benefits Summary	116
How to Contact Us	119

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 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.

- The study or investigation is conducted under an **investigational** new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an **investigational** new drug application.

- **Authorized representative** means:
  - A person to whom a **covered person** has given express written consent to represent the **covered person** in an **appeal** or external review;

- A person authorized by law to give consent on behalf of a **covered person**; or
- 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 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 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 $20 or $30 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, provide essential human services, and oversee 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 health 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** If you have an emergency medical condition, you can go to the emergency room right away, including a freestanding emergency room that is not part of a hospital. You do not need to ask your Plan first. It does not matter if the emergency room is in your Plan's network or not - you are covered either way. This includes the care you get right after you arrive, and it also includes extra care you may need to become stable. That extra care is still treated as emergency care and covered the same way, unless you are in a condition to safely be moved to an in-network hospital. The emergency room cannot charge you extra for going out of network. Any money you pay for an emergency medical condition at an emergency room counts toward your deductible, if applicable, and your yearly limit on out-of-pocket costs, just like it would at an in-network 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 Virtual Care 24/7—** The preferred vendor with whom we have contracted to provide **virtual care services** to our **members**. Our preferred vendor contracts with **providers** to render **virtual care 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 rehabilitation 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 Medicos, 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** — 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 trial** 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 and complex condition or illness** — An acute condition or chronic illness that requires specialized treatment over a period of time to avoid injury, or impairment that results in, or is likely to result in, any of the following:
  - Death or permanent harm.
  - Significant decline in physical, mental, or psychosocial functioning that is not solely due to the normal progression of a disease or aging process.
  - Loss of limb, or disfigurement.
  - Avoidable pain that is excruciating, and more than transient; or
  - Other serious harm that creates life-threatening complications/conditions

- **Serious medical condition** — A health condition or illness, which 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. You may also call Member Services 1-833-983-7272 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays 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, which 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**.

- **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 cannot 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**.
- **Virtual care services** — Includes evaluation, management, and consultation services with a professional **provider** for **behavioral health** and nonemergency medical issues via an interactive audio or video telecommunications system.

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 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 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 has not 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 an First Choice Next **health plan** you will need to make your first month's **premium** payment for the new coverage period to begin on new or renewing **policies**. If you were previously terminated by First Choice Next due to non-

payment of **premiums**, we will still allow you to enroll in a new **policy**. Premium payments paid toward the new **policy** will not be applied to any outstanding balance from a previously terminated health plan.

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 not renew, 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 three 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 do not 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://firstchoicenext.healthsparq.com/healthsparq/public/#/one/city=&state=&postalCode=&country=&insurerCode=FCNEXT_I&brandCode=FCNEXT&alphaPrefix=&bcbsaProductId=&productCode=SCEX. You can also call our Member Services number on your **member** ID card. This number is also at the end of this policy in the How to Contact Us section. **Network providers** are not employees of our plan.

This **health plans 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 Limitations 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 and 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 or the **member** agrees to sign over their rights. The **member** will not be charged for balance bills for out-of-network care (**emergency services** or care by a non-participating **provider** at an **in-network facility**) without the informed consent of the **member** or **prior authorization**. If the **member** receives incorrect information from First Choice Next about a **provider's network** status, they will only be responsible for the in-network cost share. If a **provider** or health care facility leaves our **network** and you are in active treatment or terminally ill, First Choice Next will continue to cover **covered health services** at the

member's in-network cost share for up to 90 days. Please refer to the "**Continuity/transition of care**" section of this **policy** for additional information.

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 plans** approval. Female members can select an obstetrics and gynecology doctor as their **PCP**. 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 this determination. Upon receipt of the member's request for **continuation of care** accompanied by the **physician's** attestation on the prescribed form, we will 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 and complex 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** that 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** or **in-network facility** stops participating in our **network**, they become an **out-of-network provider** or **out-of-network facility**. You may continue getting care from that **out-of-network provider** or **out-of-network facility** through your continuity of care/transition of care coverage if when the **network provider or network facility** stops participating in our **network** you are:

- Undergoing a course of treatment for a **serious and complex condition or illness;**
- Undergoing a course of institutional or inpatient care from the **provider** or facility;
- Scheduled to undergo non-elective surgery from the **provider**, including receipt of postoperative care from such **provider** or facility with respect to such a surgery.

This coverage is provided through completion of treatment, until you select another **network provider** or **network facility** as your treating physician, or until the next open enrollment period offered by First Choice Next, whichever is longer. This coverage is provided for a maximum of 90 days. We will notify you if your **in-network provider** or **in-network facility** becomes an **out-of-network provider** or **out-of-network facility**. The **out-of-network provider** or **out-of-network facility** who is 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** who have started prenatal care with a **provider** or **facility** who stops participating in our **network** can continue receiving pregnancy-related services through the date of birth of the baby and 60 days after the birth. This continuity of care time does not apply to **providers** whose participation as **network providers** has been ended for cause by the plan.

If you are found to be terminally ill when your **provider** or facility stops participating in our **network**, or at the time you enroll in our plan, and your **provider** or facility was treating your terminal illness before the date the **provider** or facility stops participating or your new enrollment in our plan, you can continue to receive care from that **provider** or facility. However, this is only true for services that directly relate to the treatment of your illness or its medical manifestations. This coverage is provided until you select another **network provider** or **network facility** as your treating physician or you reach your continuity/transition of care 90-day coverage maximum, whichever is shorter.

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
- Biomarker testing
- 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, including prosthetics and custom orthotics
  - Negative pressure wound therapy
- 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
- Home sleep studies
- **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.

- Removal of lesions

- 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
  - Health plan notification is required for any maternity delivery less than 48 hours or cesarean section surgery less than 96 hours. Obstetrical admissions and newborn deliveries exceeding 48 hours after vaginal delivery and 96 hours after cesarean section require prior authorization.
- 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
- Womens health care by **network providers** (OB/GYN services)

Behavioral health services needing prior authorization

- All out-of-**network** services, except **emergency** care
- Ambulatory detoxification
- Crisis intervention services
- Electroconvulsive therapy (ECT)
- Mobile crisis management
- Nonhospital medical detoxification
- Intensive outpatient treatment
- Partial hospitalization
- 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
- Outpatient psychiatric, substance use disorder, and medication management services not otherwise specified as needing prior authorization. For specific services please have your **provider** refer to the Prior Authorization Lookup Tool on the PA section of our plan website.

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

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 **medically necessary 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. ET, 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 1-877-486-7229. A toll-free fax line is available to receive inbound communications from **providers** 24 hours a day, seven days a week at 1-833-329-8686 and language help is also available at TTY 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 review service requests for **medical necessity.** 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 you and your **provider** of our review determination, whether adverse or not:

- Urgent concurrent requests are decided and communicated within 72 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**; jeopardize the **member's** ability to regain maximum function or in the opinion of a **physician** with knowledge of the **member's** medical condition, 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 two business days.

- 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 below time frames for you or your **provider** to send this additional information based on the type of request:

- 15 calendar days for retrospective requests

- 15 calendar days for non-urgent care prospective requests

- 48 hours for urgent care prospective requests

If a **provider** or **member** fails to provide the requested information in the required timeframe, we may deny certification of the requested service.

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 a current course of treatment (other than by plan amendment or ending) before the end of such period of time or number of treatments will result in an **Adverse Benefit Determination**. We will notify the **member** and **provider** of the **Adverse Benefit Determination**. We will notify enough in advance of the reduction or termination to allow the **member** or **provider** to **appeal** and get a decision on review of that **Adverse Benefit Determination** before the benefit is reduced or ended.

- Any request by a **member** or **provider** 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. As long as we receive the request 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 72 hours or two business days 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 **covered health care service**, we will notify the **member** and the **member's provider**. For an **Adverse Benefit Determination**, we will notify the **member** and the **member's provider** and send written or electronic confirmation of the **Adverse Benefit Determination** to the **member** and the **member's provider**. For concurrent reviews, we will be responsible for **covered health care services** until the **member** has been notified of the **Adverse Benefit Determination**. In other words, a denial does not become effective until notice is given to the **covered person**. We will notify you and 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** within three calendar days after the decision is made. We remain responsible for **covered health care services** until you have been notified of the **Adverse**

Benefit Determination. We will notify you orally or in writing.

If we issue an **adverse benefit determination** and you do not agree with our decision to deny your request, you have a right to appeal the decision. Please see the **Appeals** section of this **policy** for additional information on how to **appeal** an **Adverse Benefit Determination.**

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 Member Services at 1-833-983-7272 (TTY 711), Monday through Friday, 8-a.m. to 6 p.m. ET, excluding holidays.

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 **copayment**. 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**).

Your cost-share responsibility for the **covered health services** you receive are determined based on where the services are provided. For example, if you receive allergy testing and treatment in an office visit setting, your specialist cost-share responsibility will apply. However, if you receive allergy testing provided by an outpatient laboratory center, your laboratory outpatient professional services cost-share responsibility will apply. Please refer to your **Schedule of Benefits** to determine any limitations and cost-share responsibility that may apply to your **covered health services**.

You can ask for the **Schedule of Benefits** and other **policy** documents. Just call Member Services at 1-833-983-7272 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays. You may also access **policy** documents online at https://www.firstchoicenext.com/members/forms-and-documents.

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 when administered by an **in-network provider** in an office visit setting or by an outpatient laboratory center.

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.

Biomarker testing

We cover biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a **covered person's** disease or condition to guide treatment decisions if medical and scientific evidence indicates that the biomarker testing provides clinical utility to the **covered person**. Biomarker testing for the purposes of screening are not covered.

Blood products

We will cover the cost of transfusions of blood, plasma, blood plasma expanders, and other fluids injected into the bloodstream. Benefits are provided for the cost of storing a member's own blood only when it is stored and used for a previously scheduled procedure.

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, for covered persons younger than 26 years of age, **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
- 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 drug benefits** 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 illness, 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/behavioral health and substance use services

We cover mental/behavioral health and substance use services to diagnose and treat biologically based mental illnesses, alcoholism and substance use disorders. 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.

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.

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

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 or contact lenses per calendar year. Frames and lenses are covered up to the provider's allowed amount. If the item is requested exceeds the approved allowed amount, then the approved amount for the basic item may be applied toward the price of the item at the member's option. You are responsible for any costs over the approved amount designated by First Choice Next for an item that may be prescribed.

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**.

Doula services

A doula is an individual who has been trained to provide physical, emotional, and educational support, but not medical or midwifery care, to pregnant and birthing women and their families before, during, and after childbirth. We cover maternity support services provided by a doula to pregnant and birthing women before, during, and after childbirth. This coverage is subject to annual deductibles, member cost share responsibilities, and is limited to $1,500 per pregnancy.

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 or diagnose illness, disease, or injury.

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; cardiac rehabilitation; and pulmonary rehabilitation, 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.

Routine foot care

We cover medically necessary routine foot care including but not limited to treatment of

diabetes, metabolic disorders, neurologic disorders, and peripheral vascular disease. Routine foot care that is determined to be cosmetic is excluded from coverage and will not be covered.

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.**

Specialist visits

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

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 health plan **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.

Virtual care services

Virtual care services are covered at no cost when received through a **First Choice Next Virtual Care 24/7 in-network provider**. Certain specialty services including pediatrics are not eligible for **First Choice Next Virtual Care 24/7**. **Virtual care 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 **virtual care services** are available.

Prescription Drug Benefits

First Choice Next strives to provide you with high-quality and cost-effective drug coverage.

We use First Choice Next's Pharmacy Benefit Manager (PBM) to help manage your prescription drug benefits, including specialty medications. You will need to get your prescription medications filled from a network pharmacy to obtain coverage. Prescriptions can be filled at a retail network pharmacy, through our mail-order network pharmacy, or a network specialty pharmacy. You will need to show your member ID card when you fill or obtain your prescription medications.

The prescription drug benefits do not cover all drugs and prescriptions. Some drugs must meet certain medical necessity guidelines before we can cover them. Your provider must ask us for prior authorization before we will cover these drugs.

Formulary

The list of prescription drugs covered under this plan is called a formulary. The formulary applies only to drugs you get at retail, mail-order, and specialty pharmacies. Along with the covered drugs, the formulary also allows you to review any limitations or restrictions such as prior authorization, step therapy, quantity limits, and age limits. The formulary does not apply to drugs you get if you are in the hospital. For our latest pharmacy benefit and formulary information, please visit https://www.firstchoicenext.com/members/find-a-provider-or-pharmacy **or** call us at 1-833-983-7272 (TTY 711), Monday through Friday, 8 a.m. to 6 -p.m. ET, excluding holidays.

The formulary is a closed formulary (i.e., products not listed are treated as nonformulary); however, drugs not on the formulary can still be requested, and our pharmacy benefits manager's coverage determination and prior authorization process may allow for nonformulary exceptions.

The formulary covers both Preferred Generic and Brand drugs, and Non-Preferred Generic and Brand drugs, and will determine what your out-of-pocket costs will be under our plan based on the drug tier. Please refer to your Summary of Benefits and Coverage for more information on copays and deductibles.

Covered prescription drugs and supplies

The prescription drug benefits cover many different therapeutic classes of drugs, which you

can find at https://www.firstchoicenext.com/members/find-a-provider-or-pharmacy.aspx. You can use the searchable drug list, to search by the first letter of your medication, by typing part of the generic (chemical) or brand (trade) names, or by selecting the therapeutic class of the medication you are looking for.

Your prescription drug benefits cover prescription insulin drugs and will include at least one formulation of each of the following types of prescription insulin drugs on the lowest tier of the drug formulary developed and maintained by your health benefit plan.

- Rapid-acting
- Short-acting
- Intermediate-acting
- Long-acting

In addition to the covered prescription drugs and supplies listed in the formulary, we may cover:

- Compounded medications: If at least one active ingredient requires a prescription by law and is approved by the U.S. Food and Drug Administration (FDA). Compounding kits that are not FDA approved and include prescription ingredients that are readily available may not be covered. To confirm whether the specific medication or kit is covered under this plan, please call the Member Services team. Some compounded medications may be subject to prior authorization.
- Off-label drugs: We will also cover certain off-label uses of FDA-approved drugs in accordance with state law. 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 compendia: (1) National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium; (2) The Thompson Micromedex Drug Dex; (3) American Hospital Formulary Service; (4) Lexi-Drugs; (5) United States Pharmacopoeia-Drug Information (6) the American Medical Association Drug Evaluations; or (7) any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

Included in the formulary are:

- Hormone replacement therapy (HRT) for perimenopausal and postmenopausal individuals

- Hypodermic syringes or needles when medically necessary

Narrow therapeutic index (NTI) drugs

First Choice Next will cover certain narrow therapeutic index (NTI) brand medications. The medication may require prior authorization to be covered.

The brand formulations of the following NTI medications are eligible for coverage:

- Carbamazepine
- Cyclosporine
- Digoxin
- Ethosuximide
- Levothyroxine sodium tablets
- Lithium
- Phenytoin
- Procainamide
- Tacrolimus
- Theophylline
- Warfarin sodium tablets

Preventive medications

Under the Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA), some preventive medications may be covered at no cost (copay, coinsurance, or deductible) for First Choice Next members.

These include certain medications in the following categories:

- Bowel preparations — for members from ages 45 to 75
- Oral fluoride supplementation — for members from ages six months to five years

- Moderate-intensity statins — for members from ages 40 to 75 years
- Folic acid 400 to 800 micrograms (mcg) — for members of childbearing age
- Aspirin 81 milligrams (mg) — to prevent or delay the onset of preeclampsia
- Tobacco cessation
    - Nicotine gum
    - Nicotine lozenge
    - Nicotine patch
    - Bupropion hall (smoking deterrent) tab ER 12hr 150 mg
    - Varenicline tartrate
- HIV pre-exposure prophylaxis (PrEP)
    - Descovy (emtricitabine/tenofovir alafenamide 200 mg-25 mg), oral tablet
    - emtricitabine/tenofovir df 200 mg- 300 mg, oral tablet
    - Apretude (cabotegravir) Intramuscular Suspension Extended Release 600 Mg/3Ml
- Breast cancer primary prevention
    - Anastrozole, oral tablet 1 mg
    - Exemestane, oral tablet 25 mg
    - Letrozole, oral tablet 2.5 mg
    - Raloxifene HCL, oral tablet 60 mg
    - Tamoxifen citrate, oral tablet 10 mg and 20 mg
- Vaccines recommended by Advisory Committee on Immunization Practices (ACIP)
- Contraception —As a requirement of the Women's Prevention Services provision of the ACA, contraceptives are covered at 100% when prescribed by a participating network provider for generic products.

- Contraceptive categories include*:
  - Oral contraceptives (Rx and over-the-counter (OTC))
  - Injectable contraceptives (Rx)
  - Barrier methods (Rx) **
  - Intrauterine devices**, subdermal rods** and vaginal rings (Rx)
  - Transdermal patches (Rx)
  - Emergency contraception (Rx and OTC)
  - Condoms (OTC)
  - Female condoms (OTC)
  - Vaginal pH modulators (Rx)
  - Vaginal sponges (OTC)
  - Spermicides (OTC)

*Please see the Formulary for the most up-to-date list of products.

**Certain drugs or products may be covered as a nonpharmacy benefit (e.g., infused, injected, or implanted drugs, which are covered under medical benefits).

Note: A prescription is required for all listed medications, including over-the-counter (OTC) medications.

Prescription drug benefit exclusions

What is not covered:

- Any drug products used exclusively for cosmetic purposes
- Experimental drugs, which are those that cannot be marketed lawfully without the approval of the FDA and for which such approval has not been granted at the time of their use or proposed use, or for which such approval has been withdrawn
- Prescription drugs that are not approved by the FDA

- Drugs on the FDA Drug Efficacy Study Implementation (DESI) list
- Immunization agents or vaccines not listed on the formulary. Some immunizations may be covered under the medical benefit.
- Medical supplies*
- Prescription and over-the-counter homeopathic medications
- Drugs that by law do not require a prescription (OTC) unless listed on the formulary as covered
- Vitamins and dietary supplements (except prescription prenatal vitamins, vitamins as required by the Affordable Care Act, fluoride for children, and supplements for the treatment of mitochondrial disease)
- Topical and oral fluorides for adults
- Medications for the treatment of idiopathic short stature
- Prescriptions filled at pharmacies other than network-designated pharmacies, except for emergency care or other permissible reasons. An override will be required to allow the pharmacy to process the claim.
- Prescriptions filled through an internet pharmacy that is not a verified internet pharmacy practice site certified by the National Association of Boards of Pharmacy
- Prescription medications, when the same active ingredient, or a modified version of an active ingredient that is therapeutically equivalent to a covered prescription medication, has become available over the counter. In these cases, the specific medication may not be covered, and the entire class of prescription medications may also not be covered.
- Prescription medications when co-packaged with non-prescription products
- Medications packaged for institutional use will be excluded from the pharmacy benefit coverage unless otherwise noted on the formulary.
- Drugs used for erectile dysfunction or sexual dysfunction
- Drugs used for weight loss
- Bulk Chemicals

- Repackaged products
- Drugs used for the treatment of infertility

*Certain drugs or products may be covered as a nonpharmacy benefit (e.g., infused injected or implanted drugs, which are covered under medical benefits).

For our latest pharmacy benefit and formulary information, please visit https://www.firstchoicenext.com/members/find-a-provider-or-pharmacy or call us at 1-833-983-7272 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays.

Formulary changes

The formulary is occasionally subject to change. If a change negatively affects a medication you are taking, we will provide written notice to you before the change takes effect. We will work with you and your prescriber to transition to another covered medication if you are on a long-term prescription.

Formulary Tier Explanation (Signature Plans)

Tier 1 – Preferred Generic Drugs

Tier 2 – Preferred Brand Drugs

Tier 3 – Non-Preferred Brand and Non-Preferred Generic Drugs

Tier 4 – Specialty Drugs

Formulary Tier Explanation (All Other Plans)

Tier 1a — Preferred Generic Drugs

Tier 1b — Non-Preferred Generic Drugs

Tier 2 — Preferred Brand Drugs

Tier 3 — Non-Preferred Brand and Non-Preferred (High Cost) Generic Drugs

Tier 4a — Specialty Drugs

Tier 4b —Non-Preferred Specialty Drugs

Please see your specific “metal level” coverage for copay and coinsurance amounts.

Prior authorizations, step therapy, quantity limits, age limits, generic drug program, and other formulary tools

First Choice Next's PBM may use certain tools to help ensure your safety and so that you are receiving the most appropriate medication at the lowest cost to you. These tools include prior authorization, step therapy, quantity limits, age limits, and the generic drug program. Below is more information about these tools.

Prior authorizations (PA)

There are restrictions on the coverage of certain drug products that have a narrow indication for usage, may have safety concerns, and/or are extremely expensive, requiring the prescribing provider to obtain prior authorization from us for such drugs. The formulary states whether a drug requires prior authorization.

Step therapy (ST)

Step therapy is a type of prior authorization program (usually automated) that uses a stepwise approach, requiring the use of the most therapeutically appropriate and cost-effective agents first before other medications may be covered. Members must first try one or more medications on a lower step to treat a certain medical condition before a medication on a higher step is covered for that condition. If your provider advises that the medication on a lower step is not right for your health condition and that the medication on higher step is medically necessary, your provider can submit a request for approval.

Quantity limits (QL)

To make sure the drugs you take are safe and that you are getting the right amount, we may limit how much you can get at one time. Your provider can ask us for approval if you need more than we cover.

Quantity limits will be waived under certain circumstances during a state of emergency or disaster.

Age limits (AL)

Age limits are designed to prevent potential harm to members and promote appropriate use. The approval criteria are based on information from the FDA, medical literature, actively practicing consultant physicians and pharmacists, and appropriate external organizations.

If the prescription does not meet the FDA age guidelines, it will not be covered until prior authorization is obtained. Your provider can request an age-limit exception.

Generic drugs

Generic drugs have the same active ingredients and work the same as brand-name drugs. When generic drugs are available, we may not cover the brand-name drug without granting approval. If you and your provider feel that a generic drug is not right for your health condition and that the brand-name drug is medically necessary, your provider can ask for prior authorization.

New-to-market drugs

We review new drugs for safety and effectiveness before we add them to our formulary. A provider who feels a new-to-market drug is medically necessary for you before we have reviewed it can submit a request for approval.

Nonformulary drugs

While most drugs are covered, a small number of drugs are not covered because there are safe, effective, and more affordable alternatives available. All of the alternative drug products are approved by the FDA and are widely used and accepted in the medical community to treat the same conditions as the medications that are not covered. If you and your provider feel that a formulary drug is not right for your health condition and that the nonformulary drug is medically necessary, your provider can ask for an exception request.

Noncovered drugs with over-the-counter alternatives

First Choice Next does not cover select prescription medications that you can buy without a prescription, or “over-the-counter.” These drugs are commonly referred to as OTC medications.

In addition, when OTC versions of a medication are available and can provide the same therapeutic benefits, First Choice Next may no longer cover any of the prescription medications in the entire class. For example, nonsedating antihistamines are a class of drugs that give relief for allergy symptoms. Because many nonsedating antihistamines are available over-the-counter, First Choice Next does not cover them.

Please refer to the pharmacy formulary for a list of covered medications. As always, we encourage you to speak with your provider about which medications may be right for you.

Prior authorization and exception requests

For formulary drugs that have restrictions such a prior authorization (PA), step therapy (ST), quantity limitations (QL), and age limitations (AL), a prior authorization request may be submitted for decisions. First Choice Next's PBM will review the requests and will determine if a request meets the clinical drug criteria requirements.

For non-formulary drugs, non-formulary exception requests can be made. Non-formulary exception requests are reviewed on a case-by-case basis. Your provider will be asked to provide medical reasons and any other important information about why you need an exception. First Choice Next's PBM will review the requests and will determine if a request is consistent with our medical necessity guidelines.

We will cover nonformulary prescription drugs if the outpatient drug is prescribed by a network provider to treat a covered person for a covered chronic, disabling, or life-threatening illness if the drug:

- Has been approved by the FDA for at least one indication; and
- Is recognized for treatment of the indication for which the drug is prescribed in:
    - A prescription drug reference compendium approved by the Insurance Commissioner for purposes of this section; or
    - Substantially accepted peer-reviewed medical literature;

and

- There are no formulary drugs that can be taken for the same condition. If there are formulary alternatives to treat the same condition, then documentation must be provided that the member has had a treatment failure with, or is unable to tolerate, two or more formulary alternative medications.
- Prescription drug samples, coupons, or other incentive programs will not be considered a trial and failure of a prescribed drug in place of trying the formulary-preferred or nonrestricted access prescription drug.

  First Choice Next's PBM will review the request. If the requested drug is approved, it will be covered according to our medical necessity guidelines. If the request is not approved, then you, your authorized representative, or your provider can appeal the decision.

If the request for a nonformulary drug is approved, the medication will be covered on the highest tier. You, your authorized representative, or your provider can visit our website to review the formulary and find covered drugs. You can access a searchable and a printable formulary on our website at https://www.firstchoicenext.com/members/find-a-provider-or-pharmacy.

You*, your authorized representative*, or your provider can request for both formulary drug prior authorizations (PA, ST, QL, and AL) and non-formulary exceptions in the following ways:

Providers:

- Electronically: directly to First Choice Next's PBM, through Electronic Prior Authorization (ePA) in your Electronic Health Record (EHR) tool software, or your healthcare provider can submit through either of the following online portals:

- CoverMyMeds https://www.covermymeds.com/main/
- Surescripts https://providerportal.surescripts.net/ProviderPortal/

- By fax: 1-844-470-2508 for standard (nonurgent) requests 1-844-470-2511 for expedited (fast)* requests

- By phone: 1-877-472-7979
  Hours of operation: Monday through Friday, 8 a.m. to 6 p.m., excluding holidays

- By mail:

  200 Stevens Drive

  Philadelphia, PA 19113 CC: 236

Members:

- By phone: 1-833-779-7229
  Hours of operation: Monday through Friday, 8 a.m. to 6 p.m., excluding holidays.

*If you or your authorized representative submit the request for a prior authorization or non-formulary exception your provider must provide follow-up clinical documentation.

Once all necessary and relevant information to make a decision is received, First Choice Next's PBM will review the request. If the request is approved, they will provide an approval response to your provider with a duration of approval. If the request is denied, they will provide a denial response to you and your provider.

Prior authorization and non-formulary exception requests will be completed and notifications sent within the following time frames:

- Standard (nonurgent): no later than **72 hours** after we receive the request and any additional required information
- Expedited (fast)*: no later than **24 hours** after we receive the request and any additional required information

*Expedited (fast) requests can be made based on exigent circumstances. Exigent circumstances exist when you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug. You can indicate your exigent circumstance on the form and request an expedited review.

If the prior authorization 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.

You can ask for an appeal yourself. You may also ask a friend, a family member, your provider, or a lawyer to help you. You can call First Choice Next at 1-833-983-7272 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays if you need help with your **appeal** request. It is easy to ask us for an appeal by using one of the options below:

- Mail: Fill out and sign the Appeal Request Form in the notice you receive about our decision. Mail it to the address listed on the form. We must receive your form no later than 180 days after the date this notice
- Fax: Fill out, sign, and fax the Appeal Request Form in the notice you receive about our decision. You will find the fax number listed on the form.
- By phone: Call 1-833-983-7272 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays and ask for an appeal.

For more information on appeals, please see the section on Appeals of the Member Handbook.

Non-formulary exception request denial rights

For non-formulary exception request denials, you also have the right to pursue either a standard or, if warranted and appropriate, an expedited external review by an impartial,

third-party reviewer known as an Independent Review Organization (IRO).

You may exercise your right to external review with an Independent Review Organization (IRO) upon initial denial or following a decision to uphold the initial denial pursuant to the internal appeal process of First Choice Next. If a decision is made to uphold the initial denial, your denial notice will explain your right to external review and provide instructions on how to make this request. An IRO review may be requested in writing by the member, member's representative, or member's prescribing provider by contacting First Choice Next via mail, or fax at the following address:

- Mail:Member Appeals First Choice Next P.O. Box 7100 London, KY 40742-7101
- Fax: 1-833-722-9329

An expedited external review may be warranted if based on exigent circumstances. If your request for a standard external review is accepted, it is decided within 72 hours of receipt of your request. If your request for an expedited external review is accepted, it is decided within 24 hours of receipt of your request. We must follow the IRO's decision. If the IRO reverses our decision on a standard external review, we will provide coverage for the non-formulary item for the duration of the prescription. If the IRO reverses our decision on an expedited external review, we will provide coverage for the non-formulary item for duration of the exigency.

Filling prescriptions at the pharmacy

Retail pharmacy — You can fill up to a 30-day supply.

Mail-order pharmacy — You can fill a 31 to 90-day supply.

Specialty pharmacy — You can fill up to a 30-day supply.

Specialty drug program

We have designated specialty pharmacies that specialize in providing medications used to treat certain conditions and are staffed with clinicians to provide support services for members. Some medications must be obtained at a specialty pharmacy. Medications may be added to this program from time to time. Designated specialty pharmacies can dispense up to a 30-day supply of medication at one time, and the supply is delivered via mail to either the member's home or doctor's office in certain cases. This is not part of the mail-order pharmacy benefit. Extended-day supplies and copayment savings do not apply to these designated specialty drugs.

For Retail pharmacy, Mail-order pharmacy and Specialty pharmacy

You can use our pharmacy locator https://www.firstchoicenext.com/members/find-a-provider-or-pharmacy for all of your in-network pharmacy needs whether you need a local pharmacy, a pharmacy when you are traveling, a pharmacy to mail your prescriptions to your home, or a specialty pharmacy.

COVID-19

COVID-19 vaccines: FDA-approved COVID-19 vaccines are covered at $0 copay according to FDA-approved indications and age.

For details on the latest formulary information on COVID-19 vaccines, please visit https://www.firstchoicenext.com/members/find-a-provider-or-pharmacy.aspx or call us at 1-833-983-7272 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays.

School supplies

First Choice Next allows school supplies for the following medications:

- Insulin
- Insulin needles
- Lancets
- Test strips
- One glucometer for school
- Alcohol swabs
- Glucagon
- Inhalers
- Diastat
- Epinephrine injection solution auto-injector (generic for Epipen)
- Spacers

For our latest pharmacy benefit and formulary information, please visit

https://www.firstchoicenext.com/members/find-a-provider-or-pharmacy or call us at 1-833-983-7272 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays.

Additional Covered Health Services and Programs

First Choice Next provides coverage for additional **covered health services** and programs. These **covered health services** and programs are available to you as long as you are active on this **policy**. Some programs are only available to eligible **members** based on a clinical assessment performed by our case management team. If your coverage ends under this **policy**, all incentives, memberships, vouchers, rewards, or benefits being provided will also end. Benefits provided are in addition to the benefits described in this **policy** and certain terms and conditions may apply. The programs and their offerings are subject to change as we continue to improve your care experience. If you would like additional information on our current programs offered, contact the Member Services phone number on the back of your member ID card.

Disease management or wellness programs

First Choice Next has a case management team dedicated to supporting your medical, behavioral health, and social needs. It provides customized, integrated, person-centered care addressing all aspects of **member** wellness. The case management team will assess your needs and may direct you to one of our disease management or wellness programs that provides education, support, and care coordination services. Member eligibility for these programs is determined by the case management team based on clinical assessment.

Healthy Rewards program

First Choice Next makes available to you an optional Healthy Rewards program at no cost to you which allows you to earn incentives and rewards for completing different activities. Please note this is an incentive and rewards program and it does not offer any rebates, discounts, abatements or credits, or a reduction of **premiums**.

Optum Obstetrical Homecare program

First Choice Next makes available to qualifying members the Optum Obstetrical Homecare program. This program is designed to provide ongoing education at various stages of pregnancy, identify warning signs of preterm labor through weekly physician-prescribed assessments, and assist in the identification of high-risk pregnancy conditions. Homecare visits will be performed by an experienced nurse, and will include education and materials related to pregnancy, preterm labor, and high-risk pregnancy. The program includes access to 24/7 telephonic nursing and pharmacist support. **Member** eligibility for this program is determined by the case management team based on clinical assessment.

Tobacco cessation program

First Choice Next makes available to qualifying **members** a tobacco cessation program at no cost. The tobacco cessation program provides **members** with personalized information, support, tools, and coaching to achieve health goals related to tobacco cessation. Tobacco cessation medications such as nicotine gum, lozenges, patches, buprenorphine (smoking deterrent formulation) and varenicline tartrate are also available to members with a prescription. Please see the formulary for more details.

Weight Watchers program

First Choice Next makes available to **members** from the ages 15 to 64 vouchers for membership with Weight Watchers for up to 28 weeks at no cost.

Exclusions and Limitations

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, personality disorders, factitious disorders, sleep disorders, 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., 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 conditioners, 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
  - 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**

- Gender affirming care
- Hearing aids
- Incontinence supplies
- 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**
- Refractive laser eye surgery such as laser-assisted in situ keratomileusis (LASIK)
- Safety glasses, athletic glasses, and sunglasses; non-standard lenses such as photo color or scratch-resistant lenses
- The following habilitative services:
  - Cognitive therapy

- 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 immunization or exam services required for foreign travel or employment purposes
- 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/Complaints 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/complaint** or **appeal**. You have the right to file a **grievance/complaint**, file an **appeal**, and to an external review with respect to certain **Adverse Benefit Determinations** or **appeals** not decided in your favor.

Our **grievances/complaints** 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/complaint**. Concerns about the denial of a claim or request for service are considered **appeals**. Our **grievance/complaint** 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/complaint** 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) 8 a.m. to 6 p.m. ET, excluding holidays.

Grievances/Complaints

You, your **authorized representative**, or your **provider** can file a **grievance/complaint** with us. You can do so in writing or over the phone. If the provider files a **grievance/complaint** on behalf of the **member** and we do not have record of the **members**' consent; the **grievance/complaint** team will need to secure the **members** consent for the **grievance/complaint**. **Grievances/complaints** must be submitted within one year after the date of occurrence of the action that initiated the **grievance/complaint**. The **grievance/complaint** process is voluntary.

A **grievance/complaint** should be provided to us by you or your **authorized representative** by phone at 1-833-983-7272 (TTY 711) 8 a.m. to 6 p.m. ET, excluding holidays or in writing at:

Member Grievances
P.O. Box 7430,
London, KY, 40742-7430.

On filing your **grievance/complaint**, 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/complaint**. Filing a **grievance/complaint** will also never affect your **benefits**.

Once we have received your **grievance/complaint**, we will send you written acknowledgement within two business days of receipt of your **grievance/complaint**.

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/complaint**.

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

- The qualifications of the person or persons who reviewed your **grievance/complaint**.
- A statement from the reviewers summarizing the **grievance/complaint**.
- The reviewer's 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
PO 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/complaint**, including the name of any **health care professional** we consulted. For copies, please call Member Services at 1-833-983-7272 (TTY 711) 8 a.m. to 6 p.m. ET, excluding holidays.

Expedited grievance/complaint

If your **grievance/complaint** regards a decision or action on our part that could significantly increase risk to your life, health, or ability to regain maximum function, you can file a request for an expedited grievance/complaint with our Member Services department by phone 1-833-983-7272 (TTY 711) 8 a.m. to 6 p.m. ET, excluding holidays or in writing P.O. Box 7430, London, KY, 40742-7430.

Expedited reviews will be evaluated by an appropriate clinical peer or peers. We will notify you orally of the determination within 72 hours or as expeditiously as possible, after receipt of the expedited review request. We will then send written confirmation to you within three business days. Expedited reviews will meet all requirements of non-expedited reviews as described in our grievance/complaint procedures and per state law.

Standard appeals of an adverse benefit determination

You or your **authorized representative**, including your provider can file an **appeal** of an **Adverse Benefit Determination** verbally by calling Member Services at 1-833-983-7272 (TTY 711) 8 a.m. to 6 p.m. ET excluding holidays or in writing to P.O. Box 7100, London, KY, 40742-7100. We must receive a signed authorized representative form in order to process an **appeal** from your provider.

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 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays. 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 in a culturally and linguistically appropriate manner 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 from the date we get the expedited appeal request, or within two business days of getting all needed information to complete the appeal. 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) 8 a.m. to 6 p.m. ET, excluding holidays. 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**, whichever comes first. We will send a written notice of our determination to you, your authorized representative, or provider who initiated the request.

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/complaint** 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. 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 P.O. Box 7100, London, KY 40742-7100 or fax the request to 1-833-722-9329.

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.

- You qualify for an urgent internal appeal and ask for both an urgent internal appeal and urgent external review at the same time.

There is no time limit for expedited external review requests. They can be submitted verbally or in writing to P.O. Box 7100, London, KY 40742-7100 or by fax to 1-833-722-9329.

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.

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) 737-6160 or 1 (800) 768-3467

Fax: 1-803-737-6231

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 and 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**. Clean claims are claims submitted by a **provider** for payment for health care services provided to an enrollee that has no defect, impropriety, or particular

circumstance requiring special treatment preventing payment. First Choice Next will notify your **provider** within 20 business days for electronic claims and 40 business days for claims filed on paper of any deficiencies in the claim submitted and describe any remedy necessary to establish a clean claim. Failure of First Choice Next to notify your **provider** of deficiencies within the above timeframe will establish the submitted claim as a clean claim.

For covered, non-emergency services provided by an **in-network provider**, First Choice Next will pay or deny a clean claim within 20 business days for electronic claims and within 40 business days for claims filed on paper, from the date of receipt of the claim. We will cover **emergency services**, emergency air and ground ambulance services, and urgent care services, without the need for **prior authorization**, and without regard to whether or not the health care provider furnishing the **emergency services**, air and ground ambulance services, or urgent care services are a participating provider or a participating emergency facility. All other out-of-network services require **prior authorization**. First Choice Next will pay or deny a clean claim for covered **emergency services**, air and ground ambulance services, urgent care services, and non-participating provider services, within 20 business days for electronic claims and within 30 calendar days for claims filed on paper, from the date of receipt of the claim. Payments for emergency services, emergency air and ground ambulance services, urgent care services, or authorized out-of-network **covered health services**, with an **out-of-network provider** or an **out-of-network facility** will be made directly to the **out-of-network provider** or **out-of-network facility** who provided such services.

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.

Unless noted above, 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, except that the **provider** must be in-network where possible.

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 Name, Professional qualifications, specialty, medical school attended, residency completion board certification status, 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/privacy-notice.aspx. Or you can call Member Services at 1-833-983-7272 (TTY 711), Monday through Friday, 8 a.m. to 6 p.m. ET, excluding holidays to request a paper copy.

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.

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.

Appendix A - Coordination of Benefits

Coordination of this Contract's Benefits with Other Benefits

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules governs the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

Definitions

A. **Plan** - A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   1. Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This plan** – This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health

care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determines whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. **Allowable expense** – an Allowable expense is a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement

methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

5. The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** – A Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent –** A Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules
When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B.

1. Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan

provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

a) For a dependent child, whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

b) For a dependent child, whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care

coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (1) above shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (1) above shall determine the order of benefits; or

iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial parent;
- The Plan covering the spouse of the Custodial parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as

a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan.

   If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

Effect on the benefits of this plan

A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

Right to receive and release needed information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. First Choice Next may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. First Choice Next need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give First Choice Next any facts it needs to apply those rules and determine benefits payable.

Facility of payment

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, First Choice Next may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. First Choice Next will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right to recovery

If the amount of the payments made by First Choice Next is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Appendix B - Coordination of Benefits Summary

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all the coordination rules and procedures and does not change or replace the language contained in your insurance contract, which determines your benefits.

Double Coverage
It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of Benefits (COB) is complicated and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?
You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the "primary" or "secondary" benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state's COB rules will always be primary.

When This plan is primary
If you or a family member are covered under another plan in addition to this one, we will be primary when:

Your Own Expenses

- The claim is for your own health care expenses unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expenses

- The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child's Expenses

- The claim is for the health care expenses of your child who is covered by this plan and
- You are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule"; or
- You are separated or divorced, and you have informed us of a court decree that makes you responsible for the child's health care expenses; or
- There is no court decree, but you have custody of the child.

Other Situations

- We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits in accordance with the terms of your contract, just as if you had no other health care coverage under any other plan.

How We Pay Claims When We Are Secondary

We will be secondary whenever the rules do not require us to be primary.

How We Pay Claims When We Are Secondary

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part, or all of the allowable expenses left unpaid, as explained below. An "allowable expense" is a health care expense covered by one of the plans, including copayments, coinsurance, and deductibles.

- If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) usually have contracts with their providers.

- We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We may reduce our payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid do not exceed the total allowable expense for your claim. We will credit any amount we would have paid in the absence of your other health care coverage toward our own plan deductible.

- If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.

- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

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 6 p.m. ET, Monday to Friday, excluding holidays
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

FirstChoice℠ Next
A Product of Select Health of South Carolina, Inc.

Notice of Nondiscrimination

First Choice Next complies with applicable federal civil rights laws and does not discriminate on the basis of race; color; national origin; age; disability; or sex, including sex characteristics, including intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2). First Choice Next does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex. First Choice Next provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats. If you need these services, contact the Member Services number on the back of your card. If you believe that First Choice Next has failed to provide these services or discriminated in another way, you can file a grievance with First Choice Next, Attention: Member Grievances, P.O. Box 7430, London, KY 40742-7430, fax: **1-833-726-9329** or email **acaexchangegrievance@amerihealthcaritas.com**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, phone: **1-800-368-1019 (TTY 1-800-537-7697)**. Complaint forms are available at **https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf**.

We speak your language

We provide free language services and information to people whose primary language is not English. To talk to an interpreter, call the Member Services number on the back of your card.

Ofrecemos servicios lingüísticos e información sin cargo a las personas cuya lengua materna no es el inglés. Para hablar con un intérprete, llame al número de Servicios al Miembro que figura en el dorso de su tarjeta.

我们为母语非英语的人士提供免费的语言服务及信息。如需与翻译交谈，请拨打您的会员卡背面的会员服务部电话。

Chúng tôi cung cấp thông tin và các dịch vụ ngôn ngữ miễn phí cho những người có ngôn ngữ chính không phải là tiếng Anh. Để nói chuyện với thông dịch viên, hãy gọi đến số điện thoại của Dịch Vụ Hội Viên ở mặt sau thẻ của quý vị.

영어가 주 언어가 아닌 사람들을 위해 무료로 언어 서비스와 정보를 제공합니다. 통역사와 대화하려면 가입자 카드 뒷면에 기재된 가입자 서비스 번호로 연락하십시오.

Nagkakaloob kami ng mga libreng serbisyo sa wika at impormasyon sa mga indibidwal na ang pangunahing wika ay hindi Ingles. Upang makipag-usap sa isang interpreter, tumawag sa numero ng Member Services sa likod ng iyong card.

Мы предоставляем бесплатные языковые услуги и информацию людям, для которых английский не является родным. Чтобы обратиться к переводчику, позвоните по номеру, указанному на обратной стороне вашего удостоверения.

Wir bieten Menschen, deren Muttersprache nicht Englisch ist, kostenlose Sprachdienste und Informationen an. Wenn Sie mit einem Dolmetscher oder einer Dolmetscherin sprechen möchten, rufen Sie bitte die Nummer des Mitgliederservice auf der Rückseite Ihrer Karte an.

Nous fournissons gratuitement des services linguistiques et des informations à ceux dont la langue principale n'est pas l'anglais. Pour communiquer avec un interprète, appelez l'équipe service aux adhérents au numéro indiqué au dos de votre carte.

Prestamos informações e serviços linguísticos gratuitos a pessoas cujo idioma principal não é o inglês. Para falar com um intérprete, ligue para o número de atendimento ao beneficiário indicado no verso do seu cartão.

We speak your language

અમે એવા લોકોને નિ:શુલ્ક ભાષા સેવાઓ અને માહિતી પ્રદાન કરીએ છીએ જેમની પ્રાથમિક ભાષા અંગ્રેજી નથી. દુભાષિયા સાથે વાત કરવા માટે, તમારા કાર્ડની પાછળ આપેલ સભ્ય સેવા નંબર પર કૉલ કરો.

نقدم خدمات ترجمة مجانية ومعلومات للأشخاص الذين لغتهم الأساسية ليست اللغة الإنجليزية. للتحدث مع مترجم، اتصل برقم خدمات الأعضاء الموجود على ظهر بطاقتك.

英語を母国語としない人々に、無料の言語サービスと情報を提供しています。通訳者と話すには、カード裏面に記載されているメンバーサービス番号に電話してください。

Ми надаємо безкоштовні мовні послуги та інформацію людям, для яких англійська мова не є рідною. Для зв'язку з перекладачем зателефонуйте на номер відділу обслуговування, зазначений на зворотній стороні Вашої картки.

हम उन लोगों को मुफ्त भाषा सेवाएं और जानकारी प्रदान करते हैं जिनकी प्राथमिक भाषा अंग्रेजी नहीं है। दुभाषिए से बात करने के लिए, अपने कार्ड के पीछे सदस्य सेवाओं के नंबर पर कॉल करें।