

My employees
want great health
care coverage.
I need a plan with
more choices.



This is our plan.

Business True BlueSM

PLAN FEATURES ■ Business True Blue offers you flexible options to build a health care plan that works for you. BlueCross BlueShield of South Carolina is a proud partner with local chambers of commerce, offering plans designed for businesses just like yours.

- Design a custom plan or choose a fixed plan
- Choice of prescription drug benefits
- Access to the largest preferred provider network in South Carolina
- Optional vision and dental benefits

DUAL OPTIONS ■ Give your employees more choices. Business True Blue gives you the option of offering your employees the choice of two plans.




HIGH DEDUCTIBLE OPTIONS ■ Business True Blue also offers high deductible health plans that feature optional health reimbursement accounts. Please refer to the Business BlueSM High Deductible Health Plan or Business BlueSM High Deductible for Health Reimbursement Accounts brochure.



Design your plan.

You need health care coverage that your employees can count on. Business True Blue is designed for businesses just like yours.

BlueCross BlueShield of South Carolina has been a trusted name in health care coverage for more than 60 years and carries the assurance of an A.M. Best A+ (Superior) rating. Our flexible plan designs, outstanding network value and commitment to member service make Business True Blue the right choice for your chamber business.

-  Multiple choices available
-  Core benefits
-  Additional coverage options

Deductible Choices (per member per benefit period)

Choose one deductible level

- \$350
- \$750
- \$1,500
- \$2,500
- \$5,000 (available only with the 70/50 or 60/40 benefit options)

For family coverage, we assess a maximum of three deductibles per benefit period.

Benefit Options

Choose one coverage level

In-Network/Out-of-Network

- 90/70%
- 80/60%
- 70/50%
- 60/40%

Out-of-Pocket Maximums

Choose one

In-Network/Out-of-Network

- \$1,500/\$3,000 (available only with the 90/70 or 80/60 benefit options)
- \$2,000/\$4,000
- \$3,000/\$6,000
- \$5,000/\$10,000 (available only with the 70/50 or 60/40 benefit options)

Limited to two out-of-pocket maximums for family coverage.

Choose my Drug Coverage

Choose one

Drug Card (\$8/30/60 copayments)

Specialty drug copayment is 10 percent of allowable charges to a maximum of \$200 for up to a 31-day supply. Mail-order copayments are \$16/70/140 for up to a 90-day supply. Out-of-network coverage is paid at out-of-network benefit percentage, after the copayment.

Blue RxSM Express

Paid at allowable charges after member meets deductible and pays coinsurance. Specialty drug copayment is 10 percent of allowable charges to a maximum of \$200 for up to a 31-day supply. Mail-order medications are available. Out-of-network coverage is paid at out-of-network benefit percentage.

Copayments

Choose one

No copayment

\$15 for primary care physician/\$25 for specialists
(available only with the 90/70 and 80/60 options)

\$25 for primary care physician/\$35 for specialists

When the office visit copayment option is selected, the following services in the physician's office are covered after the applicable copayment: treatment of illness, accident or injury; injections for allergy, tetanus or antibiotics; diagnostic lab and diagnostic X-rays (chest and plain film), when performed and billed in the office on the same date. Copayments do not apply to maternity, mental health services or substance abuse care. All other services are subject to the deductible and coinsurance.

Lifetime Benefit Maximum

\$2,000,000 per member.

Physician Services

After members meet their benefit period deductible, we pay covered physician services at the plan's in- or out-of-network benefit percentages. Covered services include:

- Daily medical visits and consultations in a hospital or facility
- Medical, lab work, X-rays and other diagnostic services at a hospital outpatient department, clinic or doctor's office
- Second surgical opinions
- Initial exam of a newborn baby and nursery charges if newborn is added to employee's coverage within 31 days
- Surgery
- All other covered physician services

Enhanced Preventive Benefit Option

Choose one

- No additional coverage
- Enhanced Preventive Benefit Option

When the Enhanced Preventive Benefit is selected, we pay allowable charges at 100 percent to a benefit period maximum of \$300 for routine physical benefits when an in-network provider is used. After paying copayment, also includes well-child checkups (birth through age 6) and immunizations according to the American Academy of Pediatrics guidelines.

Preventive Screenings

Pap smear, prostate screening and lab work covered at 100 percent, in-network only. Mammography is paid at 100 percent when members use our special mammography network. Colorectal screenings covered with deductible and coinsurance.

Outpatient Hospital Services

After members meet their benefit period deductible, we pay allowable charges for covered outpatient hospital services at the plan's in- or out-of-network benefit percentages. Covered services include:

- Hospital, ambulatory surgical center or clinic charges
- Medical and surgical services
- Preadmission testing, lab work, X-rays and other diagnostic services
- All other covered outpatient services

Inpatient Hospital Services

We pay allowable charges, subject to coinsurance at in-network facilities. If members use an out-of-network facility, there is also an inpatient copayment and members must meet their deductible.

- Semi-private room and board, or special care unit
- All other covered hospital services, including surgical services and anesthesia
- Inpatient rehabilitation, with a lifetime maximum of \$100,000 per member

We require preadmission review, emergency admission review and continued stay review for medically necessary treatment for all hospital admissions.

Diabetic Supplies and Dialysis

Allowable charges are paid subject to deductible and coinsurance.

Physical Therapy




Allowable charges, subject to the deductible and coinsurance, up to \$1,000 per member, per benefit period.

Maternity	<p>Allowable charges, subject to deductible and coinsurance for the employee or a covered spouse only. Includes maternity services, surgery, anesthesia, lab work and X-rays in a hospital or at a hospital outpatient department, ambulatory surgical center, clinic or doctor's office.</p>
Newborn Care	<p>Allowable charges are paid subject to the applicable copayment, deductible and coinsurance, including the initial pediatric exam in the hospital by the doctor. Routine nursery charges are billed by the hospital upon the birth of the baby.</p> <p><i>Newborn must be added to coverage within 31 days and applicable premium paid.</i></p>
Transplant Services	<p>Human organ and tissue transplants, subject to transplant and lifetime maximums; services must be pre-authorized. Subject to all applicable copayments, deductible and coinsurance.</p>
Dental Accident Coverage	<p>Benefits to cover dental services related to an accident, if provided within 12 months of accident. Subject to all applicable copayments, deductible and coinsurance.</p>
Durable Medical Equipment (DME)	<p>We pay allowable charges subject to deductible and coinsurance; pre-authorization is required for any benefit of \$500 or more. Includes ostomy supplies and orthotics.</p>
Skilled Nursing Facility	<p>We pay allowable charges subject to deductible and coinsurance; admission must be within 14 days from hospital discharge. Preapproval is required.</p>
Home Health and Hospice	<p>We pay allowable charges subject to deductible and coinsurance; must receive preapproval.</p>
Mental Health and Substance Abuse Services	<p>Allowable charges up to \$2,000 per member, per benefit period, with a \$10,000 lifetime limit for combined inpatient and outpatient facilities, and physician services. All benefits are subject to applicable copayments, deductible and coinsurance. Companies with 51 or more employees will automatically receive additional mental health benefits for specified mental health conditions. We will cover these conditions at the same benefit level as medical conditions when your employees use in-network providers. Copayments, deductible and coinsurance still apply.</p>

Or, choose a value plan.

Want more plan choices? Business True Blue Value Plan offers four easy plans that provide a great balance of cost and benefits.

Business True Blue Value Plans offer all the advantages of BlueCross coverage — the same great provider network, the same outstanding customer service and the same peace of mind. Just choose the plan and drug coverage that works for you — it's as easy as that.

-  Multiple choices available
-  Core benefits
-  Additional coverage options

Choose your plan

Select one plan from the list of options below.

	Copayment for Office Visits*	Single Deductible*	Family Deductible*	Benefit Percentage	Single Out-of-Pocket Maximum*	Family Out-of-Pocket Maximum*
		In-Network/ Out-of-Network	In-Network/ Out-of-Network		In-Network/ Out-of-Network	In-Network/ Out-of-Network
<input type="checkbox"/> Plan 1	\$35 – Primary Care \$60 – Specialist	\$2,000/ \$4,000	\$4,000/ \$8,000	80/60	\$5,000/ \$10,000	\$15,000/ \$30,000
<input type="checkbox"/> Plan 2	\$35 – Primary Care \$60 – Specialist	\$3,500/ \$7,000	\$7,000/ \$14,000	60/40	\$5,000/ \$10,000	\$15,000/ \$30,000
<input type="checkbox"/> Plan 3	\$35 – Primary Care Specialist – Deductible/ Coinsurance	\$2,000/ \$4,000	\$4,000/ \$8,000	80/60	\$5,000/ \$10,000	\$15,000/ \$30,000
<input type="checkbox"/> Plan 4	\$35 – Primary Care Specialist – Deductible/ Coinsurance	\$3,500/ \$7,000	\$7,000/ \$14,000	60/40	\$5,000/ \$10,000	\$15,000/ \$30,000

*Note that in- and out-of-network deductibles and out-of-pocket coinsurance maximums are separate and accumulate independent of each other.

Choose my Drug Coverage

Choose one

Drug Card (\$8/30/60 copayments)

Specialty drug copayment is 10 percent of allowable charges to a maximum of \$200 for up to a 31-day supply. Mail-order copayments are \$8/70/140 for up to a 90-day supply.

Secure Card* (\$10/45/75 copayments)

Specialty drug copayment is 20 percent of allowable charge for up to a 31-day supply. Mail-order copayments are \$25/115/190 for up to a 90-day supply.

Secure Card 100* (\$10/45/75 copayments after drug deductible)

\$100 single deductible or \$250 family deductible, with copayments of \$10/45/75 thereafter. Specialty drug copayment is 20 percent of allowable charges for up to a 31-day supply. Mail-order copayments are \$25/115/190 for up to a 90-day supply.

Secure Generic Card*

Generic only coverage with \$10 copayments for up to a 31-day supply; \$20 copayment for up to a 90-day supply through the mail. Also includes some diabetic medications. Discount card for non-covered drugs.

Blue Rx Express

Paid at allowable charges after member meets deductible and pays coinsurance. Specialty drug copayment is 10 percent of allowable charges to a maximum of \$200 for up to a 31-day supply. Mail-order medications are available for up to a 90-day supply.

**Secure Card and Secure Card 100 have in-network benefits only and require the use of generics where available. For non-generic medication, the member will pay the difference in allowable charges between generic and brand-name medications after the copayment. Secure Generic Card also has only in-network benefits. Member payments for drug coverage do not go toward the medical deductible or any out-of-pocket maximum amount, except as noted above.*

Copayments

OFFICE VISITS

Primary Care Physician – \$35 per visit

Specialist – \$60 per visit (plans 1 and 2)

Deductible, then coinsurance (plans 3 and 4)

Any out-of-network provider (all plans) – Deductible, then coinsurance

Services received in a physician's office include the following: treatment of illness, accident or injury; injections for allergy, tetanus or antibiotics; diagnostic lab and diagnostic X-rays (chest and plain film), when performed and billed in the office on the same date. All other covered services are subject to the deductible and coinsurance. Copayments do not apply to maternity, mental health services or substance abuse care. Routine or preventive services are covered as shown in the contract and only when provided by an in-network provider.

Copayments

(continued)

Emergency Room –
\$100 for plans 1 and 2
\$75 for plans 3 and 4

Member pays copayment, then deductible and coinsurance. Copayment waived if admitted to hospital same day for same condition — inpatient copayment will be applied.

Outpatient –
\$150 for treatment or services

Inpatient Hospital –
\$250 hospital for admission, then member pays deductible and coinsurance

Copayments do not apply toward any deductible or coinsurance.

Physician Services

After the member meets their benefit period deductible, we pay covered physician services at the plan's in- or out-of-network benefit percentages. Covered services include:

- Daily medical visits in a hospital or facility
- Medical, lab work, X-rays and other diagnostic services at a hospital outpatient department, clinic or doctor's office
- Second surgical opinions
- Initial exam of a newborn baby and nursery charges if newborn is added to employee's coverage within 31 days
- All other covered physician services

Preventive Screenings

For Pap smear, prostate screening, lab work and routine mammograms, benefits for the actual test or screening are paid at 100 percent in-network only. Any office visit charge associated with the screening is paid as shown for office visits. Colorectal screenings are covered with deductible and coinsurance, in- or out-of-network.

Physical Therapy

Allowable charges, subject to the deductible and coinsurance, up to \$500 per member, per benefit period.

Outpatient Hospital Service

After members meet their benefit period deductible, we pay allowable charges for covered outpatient hospital services at the plan's in- or out-of-network benefit percentages. Covered services include:

- Hospital, ambulatory surgical center or clinic charges
- Emergency room facility charges (copayment applies)
- Medical and surgical services
- Preadmission testing, lab work, X-rays and other diagnostic services
- All other covered outpatient services

Inpatient Hospital Services	<p>We pay allowable charges, subject to members' applicable copayment, deductible and coinsurance. Covered services include:</p> <ul style="list-style-type: none">■ Semi-private room and board, or special care unit■ All other covered hospital services, including surgical services and anesthesia■ Inpatient rehabilitation, limited to \$5,000 per member, per benefit period, with a \$100,000 lifetime benefit <p>We require preadmission review, emergency admission review and continued stay review for medically necessary treatment for all hospital admissions.</p>
Maternity	<p>Allowable charges, subject to deductible and coinsurance for the employee or a covered spouse only. Includes maternity services, surgery, anesthesia, lab work and X-rays in a hospital or at a hospital outpatient department, ambulatory surgical center, clinic or doctor's office.</p>
Newborn Care	<p>Allowable charges are paid subject to the applicable copayment, deductible and coinsurance, including the initial pediatric exam in the hospital by the doctor. Routine nursery charges are billed by the hospital upon the birth of the baby.</p> <p><i>Newborn must be added to coverage within 31 days and applicable premium paid.</i></p>
Dental Accident Coverage	<p>Benefits to cover dental services related to an accident, if provided within 12 months of the accident. Subject to all applicable copayments, deductible and coinsurance. Limited to \$1,000 per tooth, \$3,000 per benefit period.</p>
Durable Medical Equipment (DME)	<p>Limited to \$2,500 per member, per benefit period. Members may only obtain one rental/purchase of any type of DME per benefit period.</p>
Skilled Nursing Facility	<p>Semi-private room and board, to a maximum of \$2,500 per benefit period, subject to deductible and coinsurance. Admission must be within 14 days from hospital discharge. Preapproval is required.</p>
Orthotics and Ostomy Supplies	<p>Allowable charges are covered to a combined maximum of \$1,500 per benefit period, subject to deductible and coinsurance.</p>
Standard Business True Blue Coverage	<p>Lifetime Benefit Maximum (see page 5). Diabetic Supplies and Dialysis (see page 6). Transplant Services (see page 7). Mental Health and Substance Abuse Services (see page 7).</p>

Here are the options.

❑ MyBlueDentalSM

*Choose Standard Option
or High Option*

Pays 100 percent of allowable charges on preventive care (Class I), 80 percent of allowable charges on restorative care (Class II) and 50 percent on major restorative care (Class III). Class II and Class III benefits are subject to a \$50 deductible per member, per benefit period (limited to three family members).

❑ Standard Option

Pays maximum of \$1,000 per member per benefit period

❑ High Option

Pays maximum of \$2,000 per member per benefit period

For groups of two to six, 100 percent of those enrolled in health coverage must enroll in dental coverage (if selected by the group) and an employee's dental coverage must match health coverage (if employee elects single health coverage, dental selection must also be single).

❑ **Optional Orthodontic** — Pays 50 percent of allowable charges for employees through age 18 or covered dependents through age 18. Available only to groups of 13 or more enrolled employees. Standard option orthodontic care pays \$500 lifetime maximum per member. High option pays \$1,000 lifetime maximum per member for orthodontic care.

❑ Combined Dental and Vision Benefit (AVAILABLE WITH VALUE PLANS ONLY)

Dental

Class I Preventive Care – 100 percent of allowed charges*

- Checkups: Every six months
- Cleaning: Every six months
- Bite-wing X-rays: One set per benefit period
- Emergency treatment for pain (subject to \$300 limit)

Class II Restorative Care – 50 percent of allowed charges*

- Simple and surgical teeth removal (not including impacted teeth)
- Fillings
- Anesthesia
- Oral surgery

**Combined maximum of \$300 dental benefit per benefit period*

Combined Dental and Vision Benefit
(AVAILABLE WITH VALUE PLANS ONLY)

(continued)

Vision

- Eye exam: 100 percent of allowed charges**
- Frames and lenses or contact lenses: 100 percent of allowed charges**
- Discounts also available to members through Vision One, a part of our value-added program

*** \$100 maximum per eye exam, per benefit period. \$50 maximum payment per member, per benefit period for frames and lenses or contact lenses.*

Dental/Vision level of coverage must match level of health coverage chosen.

Spinal Subluxation Services (Chiropractic)
(NOT AVAILABLE WITH VALUE PLANS)

Pays benefit percentage up to \$500 per member, per benefit period, after the deductible.

THE FOLLOWING ARE AVAILABLE FOR ALL PLANS

Supplemental Accident Coverage

Covers first \$500 at 100 percent for accidental injury each benefit period.

Companion Life Insurance Coverage

\$10,000 is standard on all health insurance contracts, with higher amounts available. You can also choose to offer your employees more options, with dependent life, short-term and long-term disability.

Companion Life is a separate life insurance company that does not provide BlueCross BlueShield of South Carolina products. Companion Life is solely responsible for its product offerings.

Dual Option

If you have seven or more employees participating in the health plan, you can give your employees additional choices by pairing your Business True Blue plans.

When you choose a dual option, the \$350 and \$750 deductible choices and the 90/70 benefit level are not available.

You can pair your Business True Blue plan with another plan for maximum flexibility. Choose from:

- Business True BlueSM Value Plan
- Business Blue High Deductible Health Plan
- Business Blue High Deductible for HRA

Plus...

My Health Toolkit

Our members enjoy the convenience of 24-hour access to information on benefits, claims and personal health information by using My Health ToolkitSM, located at www.SouthCarolinaBlues.com.

My Health Toolkit also features a physician finder, hospital comparison tool, treatment and drug cost estimators, and access to a health library. Members can also manage their health reimbursement accounts, flexible spending accounts or health savings accounts.

Out-of-Area Coverage

The BlueCard[®] and BlueCard Worldwide[®] give members access to participating doctors and hospitals across the country and around the world. You have peace of mind knowing you're covered if you get sick or injured while traveling outside of South Carolina.

It's as easy as showing your BlueCross ID card to a participating provider. We pay benefits at the same BlueCross rate members receive at home.

Money Saving Network

Our statewide network includes more than 9,000 doctors, more than 4,000 other providers and all of South Carolina's acute care hospitals. The combination of access and discount value is unbeatable. Members also have access to every Blue Cross and Blue Shield plan's provider network in the country. Finding a doctor or hospital in our network is simple and saves money.

Discount and Value-Added Programs

We are always looking for ways to make your health care dollars go further. Our members enjoy discounts on non-covered services such as fitness and weight loss programs, cosmetic surgery, vision correction, healthy reading materials and much more.

Learn more about our discount and value-added programs at www.SouthCarolinaBlues.com.

BluesEnrollSM

BluesEnroll makes group maintenance easy with 24/7 access to our online benefit administration and enrollment solution. Add new employees, delete members or change member information with the click of a mouse. Your changes are sent to us instantly, saving you time and money.

Exclusions for Business True Blue

- Before a member's policy is in effect or after he or she is no longer covered.
- Services that are not medically necessary.
- When required approvals for hospital or nursing facility charges are not obtained, room and board charges will not be paid.
- When the member is entitled to payment from other sources, or is not legally obligated to pay for the services.
- Any service or supply provided by the patient or a member of the patient's family.
- Services or treatment for complications resulting from any excluded procedure or condition.
- Prescription drugs are covered only to the extent outlined in the contract.
- Human organ and tissue transplants — only as listed in the contract. Requires preapproval.
- Investigational and experimental services.
- Cosmetic surgery, or surgery or treatment for the purpose of weight reduction.
- Sanitarium care or rest cures, long-term residential psychiatric care, custodial care and nursing homes.
- Occupational, visual or speech therapy, or private duty nursing.
- Evaluation, diagnosis or counseling for learning and behavioral disabilities; mental retardation; vocational rehabilitation; or relationship dysfunctions.
- Premarital or pre-employment physical examinations.
- Treatment for injuries resulting from intoxication over the legal limit as specified by state law or resulting from the influence of any narcotic or drug, unless taken on the advice of a physician.
- Dental services or spinal subluxation unless the employer chooses to cover these expenses.
- Eyeglasses, contact lenses, hearing aids or refractive care (including related examination), hospital or physician charges, except as specifically shown in your schedule of benefits.
- Home health and hospice care excluded on value plans.

This is a list of some of our exclusions. For a full list of excluded services and supplies, or for all limitations, please refer to the contract or your booklet.

This is where I go if I have a question.

If you have a question or need help, contact your local BlueCross BlueShield of South Carolina agent, call us at 800-641-2977 or visit us online at SouthCarolinaBlues.com.



SouthCarolinaBlues.com

VISIT US ONLINE AT SouthCarolinaBlues.com



*BlueCross BlueShield of South Carolina is
an independent licensee of the Blue Cross
and Blue Shield Association.*

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