BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA
(An Independent Licensee of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans)
COLUMBIA, SC 29219
(www.SouthCarolinaBlues.com)

How to Get Help from Blue Cross and Blue Shield of South Carolina

If you need information about the Policy benefits, call the Claims Service Center at (803) 264-3475 from the Columbia area or 1-800-868-2500, extension 43475 from anywhere else; or for changes to the Policy, call the Individual Membership area at (803) 264-6401 from the Columbia area or from anywhere else 1-800-868-2500, extension 46401.

PERSONAL BLUEPLAN℠ 2 WITH DENTAL COVERAGE LIMITED HEALTH BENEFIT INSURANCE COVERAGE POLICY FORM NO. 12339M OUTLINE OF COVERAGE

Read Your Policy Carefully

This Outline of Coverage briefly describes the important features of the Personal BluePlan 2 with Dental Coverage Policy. This is not the insurance Policy. Only the actual Policy provisions will control your Policy. The Policy itself sets forth in detail the rights and obligations of you and of Blue Cross and Blue Shield of South Carolina. It is important that you read your Policy carefully.

Major Medical Expense Coverage

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

Preauthorization Requirement

To make the most of your benefits, Blue Cross has an approval process in place. Our Medical Services personnel (a group of medical professionals employed by us) must give advance approval for all Hospital admissions and certain other specified services for you to receive maximum benefits. Their responsibility is to review all requests for preapproval. Inpatient and Outpatient services you receive for treatment of Mental Health Services and/or Substance Abuse care require Preauthorization by Companion Benefit Alternatives, Inc. (CBA). On behalf of Blue Cross and Blue Shield of South Carolina, Companion Benefit Alternatives, Inc. preauthorizes Mental Health Services and Substance Abuse services. Companion Benefit Alternatives, Inc. is a separate company.

An approval from Medical Services or Companion Benefit Alternatives, Inc. means that a service is Medically Necessary for treatment of the patient's condition. **Approval from Medical Services or Companion Benefit Alternatives, Inc. is not a guarantee or verification of benefits. Payment is subject to patient eligibility, Pre-existing Condition Limitations and all other limitations or exclusions of the Policy. Final benefit determination will be made when we process your claims.** If you have any questions about whether a certain service will be covered, please contact a Claims Service Representative.

If you or your Dependents are undergoing a human organ and/or tissue transplant, written approval from us must be obtained in advance. **If we don't preapprove these services in writing, then no benefits will be paid.**

If your Physician recommends these health care services and/or supplies for you or your Dependent for any reason, make sure you tell your Physician that your Health Insurance Policy requires advance approval. Preferred Blue® Providers will be familiar with this requirement and will get the necessary approvals.

If you or your Dependent do not use a Preferred Blue Provider, it's your responsibility to contact us before receiving these services and supplies. If you don't get preapproval, then you'll pay more of your own money for these services and supplies.

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Benefit Description

Benefit Choices

You choose one of the following benefit options: 70/50 or 60/40.

Personal BluePlan allows you to use Blue Cross' Preferred Blue Provider network*. These Providers will file your claims to Blue Cross, get approvals from Blue Cross, charge no more than the Preferred Blue Provider allowance, ask you to pay only Deductibles, Copayments and Coinsurance, charges for services that are excluded from coverage and charges for services that have exceeded the Maximum Payment.

* All references to the Preferred Blue Provider network also include the National and International BlueCard® PPO network.

Lifetime Maximum Payment for Each Covered Person

$2,000,000 including $10,000 for Mental Health Services and/or Substance Abuse care (Inpatient and Outpatient combined), $100,000 for Inpatient Physical Rehabilitation and the Transplant Lifetime Maximums for each Covered Person. The Transplant Lifetime Maximums are the maximum amounts we will pay for each of the following transplants. For transplants not listed, we will determine the Transplant Lifetime Maximum on an individual basis.

Transplant	Maximum
• Kidney, single/double	$60,000
• Pancreas and kidney	$150,000
• Heart	$120,000
• Lung, single/double	$150,000
• Liver	$200,000
• Pancreas	$80,000
• Heart and single/double lung	$200,000
• Bone Marrow	$200,000

Benefit Period Maximum Payment for Each Covered Person

Short-term Therapy Services $1,000

Deductible for Each Covered Person Each Benefit Period

You choose the Deductible under the Personal BluePlan Policy. The Deductible applies to all Covered Services, except Special Dental Services, when the Copayment does not apply, unless indicated below. The Deductible does not go toward reaching the Out-of-pocket Expense Limit.

Deductible choices are: $250, $500, $1,000, $1,500, $2,000, $3,000 or $5,000

The Policy provides benefits for covered Special Dental Services after the Special Dental Services Deductible is met. The Special Dental Services Deductible applies to covered Class II and Class III Dental services.

Copayments

$0 Copayment – Admissions to Preferred Blue Facilities
$250 Copayment* – Admission to non-Preferred Blue Facilities

*The Deductible also applies.

Copayments do not go toward reaching the Out-of-pocket Expense Limit and will continue even after the Out-of-pocket Expense Limit has been met.

Specialty Drug Copayments

Specialty Drug Copayment – per Dose

Specialty Drug Network Providers
10% of Allowable Charges not to exceed $200

Specialty Drug Copayments don't apply to the Out-of-pocket Expense Limit and will continue even after the Out-of-pocket Expense Limit has been met.

Out-of-pocket Expense Limit

You choose the Out-of-pocket Expense Limit under the Personal BluePlan Policy.

The Out-of-pocket Expense Limit choices are:

$1,500 for Preferred Blue Providers and $3,000 for non-Preferred Blue Providers
– OR –
$2,500 for Preferred Blue Providers and $5,000 for non-Preferred Blue Providers
– OR –
$3,000 for Preferred Blue Provider and $6,000 for non-Preferred Blue Providers
– OR –
$5,000 for Preferred Blue Providers and $8,000 for non-Preferred Blue Providers

Out-of-pocket Expenses are portions of Covered Services that each Covered Person must pay. For example, if the Policy pays 80% of Allowable Charges, the Covered Person must pay the remaining 20% Coinsurance amount. Deductibles, Copayments, Specialty Drug Copayments, Coinsurance for Mental Health Services and/or Substance Abuse care, Coinsurance for Special Dental Services; charges in excess of the Allowable Charge, amounts exceeding any Maximum Payments for benefits and non-covered amounts do not apply to the Out-of-pocket Expense Limit.

Except for Mental Health Services and/or Substance Abuse care and Special Dental Services, Covered Services will be paid at 100% of Allowable Charges for both Preferred Blue Providers and non-Preferred Blue Providers (except Non-contracting Facilities) for the rest of the Benefit Period when the Out-of-pocket Expense Limit is reached.

Non-contracting Facilities

No benefits are payable for services or supplies provided by a Non-contracting Facility within the State of South Carolina, except when care is provided for an Emergency Medical Condition, as described below. When services are provided by Non-contracting Facilities located outside of the State of South Carolina, benefits will be provided at a lower Rate of Payment unless the services or supplies are provided for an Emergency Medical Condition.

Emergency Medical Care By Non-contracting Facilities

If you or a covered Dependent receives Emergency Medical Care from a Non-contracting Facility, benefits for Covered Services will be paid at the Preferred Blue Provider Rate of Payment if you meet all of these conditions:

- Care must be for an Emergency Medical Condition or it must be determined by us that you or your covered Dependent had no control over the administration of Emergency Medical Care; and
- We must be notified within 24 hours or the next workday, whichever is later, if an Inpatient admission is Medically Necessary due to an Emergency Medical Condition.

Benefits under this provision are subject to the Deductible, the non-Preferred Blue Provider Copayments and Out-of-pocket Expense Limit and to all Policy maximums, limits and exclusions. You will also be responsible for the difference between the actual charge and the Preferred Blue Provider Rate of Payment.

Coverage under these circumstances continues only so long as the Emergency Medical Condition exists. Any follow-up care must be provided by a Preferred Blue or non-Preferred Blue Provider for services to be covered.

The BlueCard Program

The "BlueCard Program" means the program in which all Blue Cross and Blue Shield Plans participate. This program benefits Blue Cross and Blue Shield members who receive Covered Services outside the geographic area that Blue Cross and Blue Shield of South Carolina serves. The Blue Cross and Blue Shield Plan where you are is treated is the "Host Plan."

Whenever you receive health care services through BlueCard outside our service area, the amount you pay for Covered Services is calculated on the **lower** of:

- The billed charges for your Covered Services; or

- The negotiated price that the Host Blue Cross and/or Blue Shield Plan passes on to us.

Blue Cross and Blue Shield of South Carolina is the entity with which you have the policy. The Host Plan is only responsible for contracting with its participating out-of-area Providers and handling all interaction with its participating out-of-area Providers under the BlueCard Program.

Often, this "negotiated price" will be a simple discount that reflects the actual price the Host Plan pays. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that includes settlements, withholds, non-claims transactions (such as provider advances) and other types of variable payments. Occasionally, it may be an average price, based on a discount that results in expected average savings after taking into account the same special arrangements used to obtain an estimated price. Average prices tend to vary more from actual prices than estimated prices.

Negotiated prices may be adjusted going forward to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Laws in a small number of states may require the Host Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered health care services according to the applicable statute in effect when you received care.

Covered Services

Daily Hospital Room and Board	Semi-private room or Intensive Care Unit.
Other Covered Hospital Services	Ancillary Hospital services; Outpatient Hospital services; Outpatient Surgery; Emergency Medical Care; Outpatient diagnostic, X-ray and lab services; chemotherapy; inhalation therapy; physical therapy; radiation therapy.
Physician Services	Surgery; administration of anesthesia; daily Hospital medical care; Outpatient services; treatment of accidents; non-routine office visits.
Therapy Services	When Medically Necessary and ordered by a Physician.
Preventive Benefits	Routine OB-GYN Examination – For any female Covered Person, limited to two examinations annually. The services must be provided by a Preferred Blue Provider and don't include lab and x-ray. Routine Pap Smear Screening – Limited to one per Benefit Period for any female Covered Person, or more often if recommended by a medical doctor. A Preferred Blue Provider must provide the services. Routine Prostate Examinations, Screening and Laboratory Work – When performed according to the most recently published guidelines of the American Cancer Society (Web site: www.cancer.org). A Preferred Blue Provider must provide the services. Routine Mammography – 100% of Allowable Charges for any female Covered Person according to the most recently published guidelines of the American Cancer Society (Web site: www.cancer.org). A Contracting Mammography Provider must provide the services.
Home Health Care	Medical services for the first 40 Home Health Care visits per Benefit Period.

Hospice Care	Medically Necessary services when ordered by a Physician and when the patient is diagnosed with less than six months to live.
Prescription Drugs	We will cover only the most cost-effective Prescription Drugs available at the time the prescription is filled, including the use of Generic Drugs, according to all legal and ethical standards. Prescription Drugs must be consistent with the diagnosis and treatment of a covered illness, injury or condition, or not excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care. Benefits for the daily dosage of a Prescription Drug will be provided as recommended as described in the current *Physician's Desk Reference* or as recommended under the guidelines of our Pharmacy Benefit Manager, whichever is lower. Some Prescription Drugs require Preauthorization by us prior to being filled. Please contact the Claims Service Center to see if a specific drug requires Preauthorization. Prescription Drugs exclude oral birth control, contraceptives and contraceptive devices and are limited to 31-day supply. Specialty Drugs are not covered under this benefit. **Benefits will not be provided or paid for the following:** 1. Service charge or handling fee for a Prescription Drug. 2. Prescription Drugs that are not Medically Necessary. Prescription Drugs received from a Contracting Pharmacy – After the Deductible has been satisfied, benefits will be based on the option you chose. Prescription Drugs received from a Non-Contracting Pharmacy – After the Deductible has been satisfied, benefits will be based on the option you chose.
Specialty Drugs	A Physician must prescribe Specialty Drugs. A Specialty Drug Network Provider must fill the prescription drug. Benefits will not exceed the amount for which prior approval was given. You may obtain a list of Specialty Drugs by contacting the Claims Service Center or you can get the list from our Web site at www.SouthCarolinaBlues.com. Specialty Drugs – Per Dose Specialty Drug Network Providers – 100% of the Allowable Charge after each Specialty Drug Copayment. All other Pharmacy Providers – No Benefits. Specialty Drugs must be consistent with the diagnosis and treatment of a covered illness, injury or condition, or not excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care. **Preauthorization is required for Benefits to be available**. Benefits will not be provided or paid for the following: 1. Service charges or handling fees for a Specialty Drug. 2. Specialty Drugs that are not Medically Necessary.
Other Covered Services	Dental services related to accidental injury; Prosthetic Appliances, Orthotic Devices and Durable Medical Equipment; oxygen and equipment for its use; Medical Supplies; ambulance service; blood and blood plasma; out-of-country services and supplies.

Benefits are available when Covered Services are Medically Necessary.

The Policy requires the use of Designated Providers for specialized services including, but not limited to Inpatient care in Rehabilitation Facilities. When a Designated Provider does not perform these services, no benefits will be paid.

For a complete Summary of Benefits, please refer to the *Covered Services* section of the Personal BluePlan 2 with Dental Coverage Policy and to any Endorsements you choose.

Optional Coverage

The following optional benefit is available at an additional premium.

Optional Prescription Drug Card

Copayments*	$4 for Generic Drugs $30 for Preferred Drugs $60 for Non-preferred Drugs 10% of Allowable Charges not to exceed $200 for Specialty Drugs

* Copayments must be paid each time you or a Covered Dependent has a prescription filled even if the Deductible has been met.

The Prescription Drug Coinsurance does apply to the Out-of-pocket Expense Limit.

Prescription Drugs exclude oral birth control, contraceptives and contraceptive devices and are limited to a 31-day supply. However, a 90-day supply of maintenance drugs will be available with 3 Prescription Drug Copayments.

Benefits for Generic, Preferred and Non-preferred Drugs:

Contracting Pharmacy – After the Copayment has been satisfied benefits will be provided at:
100% of Allowable Charges for a single Prescription Drug for a Covered Person.

Non-Contracting Pharmacy – After the Copayment has been satisfied benefits will be provided at:
The non-Preferred Blue Provider Rate of Payment for a single Prescription Drug for a Covered Person.

Benefits for Specialty Drugs:

Specialty Drug Network Providers – Per Dose, We Pay:
Benefits will not exceed the amount for which prior approval was given.

100% of the Allowable Charge after each Specialty Drug Copayment.

All other Pharmacy Providers – We Pay:
No Benefits.

Special Dental Services Benefit Description

The Policy provides coverage for Special Dental Services. Some of the Covered Services include exams, X-rays, cleanings, fillings, extractions, oral Surgery, crowns, bridges, dentures and periodontal services.

Benefits for Special Dental Services are limited to $500 for each Covered Person each Benefit Period. A $25 Deductible for each Covered Person each Benefit Period applies to covered Special Dental Class II and Class III Services. No benefits are available for orthodontics except for treatment of Cleft Lip and Palate. A 12-month waiting period applies to prosthodontic, periodontic and endodontic services.

The following chart describes what Special Dental Services are Covered Services.

CLASS	COVERED SERVICES	BENEFITS
CLASS I — Diagnostic and Preventive Services	· Dental examination and diagnosis once each Benefit Period. · Full mouth X-rays once every five years. The five-year period begins on the date you have full mouth X-rays after coverage becomes effective. · Supplementary bitewing X-rays once every three years. The three-year period begins on the date you have supplementary bitewing X-rays after this coverage becomes effective · Cleaning, scaling and polishing of teeth once each Benefit Period. · Fluoride treatment for the Covered Person if he or she is under age 19, once each Benefit Period. · Emergency palliative treatment for pain relief. · Space maintainers for prematurely lost deciduous (baby) teeth for the Covered Person if he or she is under age 19. · Diagnostic casts not made in conjunction with any type of prosthodontics (Class III). · Pulp vitality tests. · Sealant on permanent teeth that have not had any fillings for children ages 6 to 15.	80% of Allowable Charges subject to the Maximum Payment
CLASS II — Basic Dental Services and Oral Surgery	· Fillings consisting of amalgam and tooth-colored synthetic materials. · Simple extractions. · Oral Surgery. · Medically Necessary general anesthesia administration during oral Surgery. · Medically Necessary services of an assistant surgeon during covered dental Surgery. · Management of acute infections and oral lesions.	60% of Allowable Charges subject to the Special Dental Services Deductible and the Maximum Payment
CLASS III — Prosthodontic, Periodontic and Endodontic Services	· Inlays that are not part of a bridge. · Crowns that are not part of a bridge. · Onlays that are not part of a bridge. · Removable dentures (complete and partial) and bridges (fixed and removable) every five years, except those needed because of loss or theft. The five-year period begins on the date you get dentures or bridges after the coverage becomes effective. · Fixed bridge and removable denture repair. · Relining or rebasing of removable dentures every six months after initial placement, then once every three years thereafter. · Pulp capping and root canal treatment. · Hemisection. · Apicoectomy (amputation of the apex of a tooth root). · Surgical periodontic examination. · Gingival curettage. · Gingivectomy and gingivoplasty. · Osseous Surgery including flap entry and closure. · Mucogingivoplastic Surgery. · Periodontal cleanings once every three months after the initial periodontic treatment is documented.	40% of Allowable Charges subject to the Special Dental Services Deductible and the Maximum Payment

Optional Endorsements

The following optional endorsements are available for an additional premium.

Supplemental Accident Endorsement

This optional endorsement provides benefits at 100% of Allowable Charges for the first $500 for Covered Services incurred by you or your covered Dependent due to accidental injury. Any amounts over $500 are payable under the regular Policy benefits and are subject to the Deductible and Coinsurance.

Benefits under the Supplemental Accident Endorsement are limited to $500 per Covered Person per Benefit Period.

Optional Maternity Endorsement

The optional Maternity Endorsement is only available to you or your covered spouse. No coverage is available for Dependent children.

Benefits for pregnancy are payable at the percentage below if: 1) the pregnancy is determined by a Physician to have begun more than 30 days after this optional coverage is purchased, and 2) the pregnancy ends while the optional endorsement is in force. The period of time is measured from the Effective Date of the optional endorsement.

Maternity Schedule

Period of Time	Percentage of Allowable Charges Payable
Allowable Charges incurred during the first 12 months the optional endorsement is in force	No Benefits
Allowable Charges incurred from the 13th month through the 24th month the optional endorsement is in force	60%
Allowable Charges incurred from the 25th month through the 36th month the optional endorsement is in force	80%
Allowable Charges incurred from the 37th month and after the optional endorsement is in force	100%

Covered Services only include:

1. Pre-natal services normally associated with a pregnancy. Pre-natal services include the following when Medically Necessary: pre-natal profile; pregnancy test and blood tests including immunoglobulin, hemoglobin and glucose tolerance tests; ultrasound/echography; urinalysis; vaginal culture; chlamydia study; pelvimetry, fetal non-stress or stress tests; rhogam injection and cerclage.
2. Medically Necessary delivery services normally associated with a vaginal delivery, including the use of pitocin and other labor inducing drugs and stillbirth after 26 weeks.
3. Routine newborn nursery care from the moment of birth until the child is discharged from the Hospital.

The following are not covered:

1. Charges for educational materials.
2. Charges for infertility diagnosis and treatment, including, but not limited to: drugs, artificial insemination, in-vitro fertilization, surrogate pregnancy, fees associated with sperm banking or reversal of sterilization.
3. Complications of Pregnancy, as defined in the Policy, are covered under the Policy and not under the Endorsement. Charges incurred due to Complications of Pregnancy will be subject to any Policy Deductible, Rate of Payment provisions and all other Policy provisions.

Exclusions and Limitations of the Policy

Except as specifically provided in the Policy, no benefits will be provided for:

1. Treatment provided in a government Hospital that you are not legally responsible for; or for which benefits are provided under Medicare or other governmental programs (except Medicaid);
2. Any charges for services or supplies for which you are entitled to payment or benefits (whether or not you have applied for such payment or benefits) under any motor vehicle no-fault law;
3. Injuries or diseases paid by workers' compensation (if a workers' compensation claim is settled, then we'll consider it paid by workers' compensation);
4. Separate charges for services provided by employees of Hospitals, laboratories or other institutions; for services or supplies performed or furnished by a member of the Covered Person's immediate family; and for services for which a charge is normally not made in the absence of insurance;
5. Cosmetic Surgery: Cosmetic Surgery does not include reconstructive Surgery when service is incidental to or following Surgery resulting from trauma, infection or other diseases of the involved part, except as allowed in the Policy, or reconstructive Surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect;
6. Illness contracted or injury sustained as the result of: war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or an auxiliary unit;
7. Rest cures and Custodial Care;
8. Transportation, except as shown in *Covered Services*;
9. Routine physical examinations, except as shown in *Covered Services*;
10. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. This exclusion does not include corrective Surgery or treatment for metabolic or peripheral vascular disease;
11. Dental care or treatment, except as shown in *Covered Services* and provided under *Special Dental Services*, as follows:
    a. Orthodontic treatment, services and supplies except orthodontics necessary for care and treatment of Cleft Lip and Palate.
    b. Services or supplies related to teeth that were missing before the Effective Date of coverage.
    c. Implants or bridges involving implants.
    d. Appliances or restoration to increase vertical dimension or restore an occlusion.
    e. Services or supplies for cosmetic or aesthetic purposes including personalized or characterization of dentures.
    f. Replacement of a denture that could have been repaired or extended.
    g. Treatment after you are no longer covered even if treatment began before this coverage was cancelled. Benefits are payable for dentures ordered and fitted while coverage was still in effect if the dentures are delivered within 31 days of the cancellation date. Benefits may also be payable for completion of Special Dental Services that are part of a treatment plan approved by us before the cancellation date if the services are completed within 30 days of the date the treatment plan was approved.
    h. Treatment that is more expensive than necessary. If you or your dentist or oral surgeon choose a course of treatment that is more expensive than that of other providers, benefits are payable for the less costly procedure if it is consistent with accepted standards of dental practice.
    i. Services or supplies for which the provider does not charge.
    j. Charges for missed appointments or for non-dental services, such as completion of claim forms, reports or booklets.
    k. Charges for visits at home or in the Hospital, except in connection with emergency care.
    l. Services submitted after the time limit for filing claims has expired.
12. Eyeglasses; contact lenses (except after cataract Surgery) and hearing aids and examinations for their prescribing or fitting;

13. Normal pregnancy or childbirth, except as provided when the Optional Maternity Endorsement is purchased. Your application and the Schedule Page of the Policy will show if you purchased the Optional Maternity Endorsement;
14. Treatment, services or supplies received as a result of suicide, attempted suicide or intentionally self-inflicted injuries whether the patient was sane or insane;
15. Services, care or supplies used to detect and correct by manual or mechanical means, structural imbalance, distortion or subluxation in your body for purpose of removing nerve interference and its effects when this interference is the result of or related to distortion, misalignment or subluxation of, or in, the spinal column;
16. Any service or supply related to dysfunctional conditions of the muscles of mastication or derangement of the temporomandibular joint (TMJ), including office visits, splints, braces, guards, etc. This exclusion, however, will not apply to Medically Necessary surgical correction of disorders of TMJ. As used in this exclusion, Medically Necessary surgical correction of TMJ means: surgical correction of skeletal malrelationships or deformities of the jaws that cause documented chronic, persistent pain or debilitating loss of function and have required treatment or medication. The presence of a documented congenital anomaly alone does not establish medical necessity. Preauthorization is required.

Pre-Existing Conditions

Services or supplies for Pre-existing Conditions are not covered until the patient has been insured for 12 months under the Policy.

A Pre-existing Condition is a condition:

1. That is misrepresented or not revealed in the application and for which symptoms existed before the Effective Date of coverage under the Policy that would cause a reasonable person to seek diagnosis, care or treatment; or
2. For which medical advice or treatment was recommended by or received from a Physician.

Pre-existing Conditions do not include congenital anomalies of a covered Dependent child.

Genetic Information will not be treated as a Pre-existing Condition in the absence of a diagnosis of the condition related to such information.

Individual Transfer Right

Any person purchasing an individual accident, health or accident and health insurance policy, will have the right to transfer to any individual policy of equal or lesser benefits offered for sale by Blue Cross and Blue Shield of South Carolina at the time transfer is sought. Any special provision excluding coverage for a specified condition may remain after the transfer, and any waiting period or Pre-existing Condition limitation period specified in the Policy to which transfer is made may be required to be served after the transfer.

About Premiums

We have the right to change the table of premiums on a class basis. If the table of premiums changes, you will be notified at least 31 days before the date that the change affects you.

Note that your premium also changes as you enter an older attained age group.

For information about premiums, please see page 1 of the Personal BluePlan 2 with Dental Coverage Policy.

Extension of Benefits After Termination of Coverage

In the event your Policy is non-renewed, coverage may be extended if you or your covered Dependents are in the Hospital or if you or your covered Dependents are Totally Disabled when coverage under this Policy ends.

We will extend benefits to the earlier of: 1) the date the hospitalization ends or the date of recovery from the Total Disability; or 2) all benefits are used; or 3) 12 months from the termination date. Benefits will be paid only for the treatment of the disabling medical condition and only for Covered Services as listed in the Policy.

The terms Totally Disabled/Total Disability mean the Covered Person is unable to perform the duties of his or her occupation and is under the care of a Physician. A child who is Totally Disabled is receiving ongoing medical care by a Physician and is not able to perform the usual and customary activities of a child in good health of the same age and sex.

Important Note: You should notify us if you wish to exercise the Extension of Benefits rights. In order for us to recognize Extension of Benefits and ensure proper payment, claims must be accompanied by a Physician's statement of disability.

Renewability Provision

You may renew the Policy on any premium due date by paying the premium required at the time of renewal and within the grace period. We may non-renew the Policy:

1. For failure to pay the premiums according to the terms of the Policy or we have not received timely premium payments; or
2. For performance of an act or practice that constitutes fraud or an intentional misrepresentation of a material fact under the terms of the Policy; or
3. If we decide to discontinue offering the Personal BluePlan 2 with Dental Coverage Policy for everyone who has it. However, coverage may only be discontinued if we:
   a. Provide notice to each individual covered by the Personal BluePlan 2 with Dental Coverage Policy of the discontinuance at least 90 days before the date the Policy is discontinued;
   b. Offer to each individual covered by the Personal BluePlan 2 with Dental Coverage Policy, the option to purchase other individual Health Insurance coverage currently offered by us; and
   c. Act uniformly without regard to any Health Status-related Factor of enrolled individuals or individuals who may become eligible for coverage in exercising the option to discontinue the Policy or offering the option to purchase other individual coverage.
4. At the time of renewal, we may modify the Personal BluePlan 2 with Dental Coverage Policy for everyone who has it as long as the modification is consistent with state law and effective on a uniform basis.

However, we will not decline to renew your Policy simply because of a change in your physical or mental health or any changes in the physical or mental health of any insured Dependents.