

Schedule of Benefits for Personal BlueSM Basic

Policyholder's Name: Your Name
 Policyholder's ID Number: Your Policy ID Number
 Date of Birth: Your Date of Birth
 Type of Plan: SINGLE or FAMILY
 Effective Date: Your Effective Date will be either the 1st or the 15th of the month
 Benefit Period: Begins on Your Effective Date of Coverage and continues for 365 (366 for leap year) or January 1 through December
 Covered Dependents: Dependents Names, if covered

Benefit Description and Premium Schedule

Form	Benefit Description	Premium
13034M-A	Personal Blue Basic	
13036M-A	Personal Blue Basic Limited Benefits Health Insurance	Your Premium
	Blue Rx	
	Basic Card	
	Secure Card	
	Generic Card	
	Drug Card	Type of Drug Coverage Chosen and Premium
	Optional Dental and Vision Coverage	Premium or Not Purchased
	Optional Accident Medical Expense	Premium or Not Purchased
	Optional Maternity	Premium or Not Purchased
	Total <u>Monthly</u> Premium	Total Premium

Schedule of Benefits for Personal BlueSM Basic

(continued)

Deductible – You pay

Single In-Network Providers / Out-of-Network Providers	Family In-Network Providers / Out-of-Network Providers
Plan 1 – \$500 / \$1,500	Plan 1 – \$1,500 / \$4,500
Plan 2 – \$500 / \$1,500	Plan 2 – \$1,500 / \$4,500
Plan 3 – \$1,000 / \$3,000	Plan 3 – \$3,000 / \$9,000
Plan 4 – \$1,000 / \$3,000	Plan 4 – \$3,000 / \$9,000
Plan 5 – \$1,500 / \$4,500	Plan 5 – \$4,500 / \$13,500
Plan 6 – \$1,500 / \$5,000	Plan 6 – \$4,500 / \$13,500
Plan 7 – \$2,500 / \$5,000	Plan 7 – \$5,000 / \$10,000
Plan 8 – \$5,000 / \$10,000	Plan 8 – \$10,000 / \$20,000

The Deductible is per Member per Benefit Period for single coverage or per family for family coverage for both In-network Providers and Out-of-network Providers.

The In-network Deductible does not apply to the Out-of-network Deductible and the Out-of-network Deductible does not apply to the In-network Deductible.

Deductibles do not apply to the Out-of-pocket Maximums.

Copayments – You pay

\$15 Primary Care Physician for Plans 1 through 6
 \$25 Specialists for Plans 1 through 6
 \$150 Emergency Room
 \$200 Outpatient Visit
 \$300 Inpatient Admissions

Copayments for Emergency Room, Outpatient visits and Inpatient admissions are for In-network and Out-of-network Providers.

Copayments for Primary Care Physicians and Specialists are In-network Only.

Copayments do not apply to the Deductibles or the Out-of-pocket Maximums.

Copayments will continue even after you reach your Out-of-pocket Maximum

Out-of-pocket Maximum – You pay

Single In-Network Providers / Out-of-Network Providers	Family In-Network Providers / Out-of-Network Providers
Plan 1 – Unlimited / Unlimited	Plan 1 – Unlimited / Unlimited
Plan 2 – \$5,000 / \$10,000	Plan 2 – \$10,000 / \$20,000
Plan 3 – \$5,000 / \$10,000	Plan 3 – \$10,000 / \$20,000
Plan 4 – \$5,000 / \$10,000	Plan 4 – \$10,000 / \$20,000
Plan 5 – \$6,000 / \$12,000	Plan 5 – \$12,000 / \$24,000
Plan 6 – \$6,000 / \$12,000	Plan 6 – \$12,000 / \$24,000
Plan 7 – \$7,500 / \$15,000	Plan 7 – \$15,000 / \$30,000
Plan 8 – Unlimited / Unlimited	Plan 8 – Unlimited / Unlimited

The Out-of-Pocket Maximum is per Member per Benefit Period for single coverage or per family for family coverage for both In-network Providers and Out-of-network Providers.

Covered Services will be paid at 100% of the Allowable Charges when you reach your Out-of-pocket Maximum. However, the Covered Services for Mental Health Services and/or Substance Abuse Care **won't be** increased to 100%.

The Out-of-Pocket Maximum doesn't include any Deductibles, Copayments, Coinsurance amounts for Mental Health Services and/or Substance Abuse care, Coinsurance for Maternity or Dental Services (when purchased), charges in excess of the Allowable Charge; amounts exceeding any Maximum Payments for benefits; or any expense not allowed according to any provisions of this coverage.

The In-network Out-of-pocket Maximum does not apply to the Out-of-network Out-of-pocket Maximum and the Out-of-network Out-of-pocket Maximum does not apply to the In-network Out-of-pocket Maximum.

This coverage an unlimited Out-of-pocket Maximum, benefits provided under this coverage will not be increased to 100%.

Schedule of Benefits for Personal BlueSM Basic
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Benefit Period Maximum – We Pay
(All Benefit Period Maximums are per Member per Benefit Period)

\$750,000 for Benefit Periods beginning 9/23/2010 through 9/22/2011;
 \$1,250,000 for Benefit Periods beginning 9/23/2011 through 9/22/2012;
 \$2,000,000 for Benefit Periods beginning 9/23/2012 through 12/31/2013; and
 Benefits Periods beginning 1/1/2014 there will be no annual dollar limits for essential health benefits. Essential benefits include the following more restrictive limits:

60 days for Skilled Nursing Facility Services
 60 visits for Home Health Care
 30 visits for Short-Term Physical Therapy Services and Occupational Therapy combined
 20 visits for Speech Therapy
 25 Outpatient/Physician visits and 7 days Inpatient for Mental Health Services and/or Substance Abuse Care

Separate Benefit Period Maximums apply to the following:
 \$50,000 for Prosthetics
 6 months per episode for Inpatient and Outpatient Hospice Care

All benefits payable on Covered Services are based on our Allowable Charges. All Covered Services must be Medically Necessary.

All admissions require Preadmission Review or Emergency Admission Review, and Continued Stay Review. If Preadmission Review is not obtained for all Facility admissions, room and board will be denied. If approval is not obtained for Emergency Admissions within 24 hours or by 5 p.m. of the next working day following the admission, room and board will be denied.

Treatment for the following outpatient services requires Preauthorization Review: Mental Health Services and Substance Abuse care, chemotherapy or radiation therapy (first treatment only), hysterectomy and septoplasty. If Preauthorization is not obtained, appropriate Benefits will be paid after a 50% reduction in the Allowable Charge.

Treatments for these services also require Preauthorization Review: Home Health Care, Hospice Care, human organ and/or tissue transplants, inpatient rehabilitation services, certain Prescription Drugs, MRIs, MRAs, CT Scans or PET Scans in an Outpatient facility or Physician's office, Prosthetic Devices, and Durable Medical Equipment (DME) when the purchase price or total rental cost of the DME is \$500 or more. If Preauthorization is not obtained, no benefits will be paid.

Treatment for hemophilia must be coordinated through a Center for Disease Control designated hemophilia treatment center at least once per Benefit Period or benefits will be reduced to 50% of the Allowable Charge.

	WE PAY IN-NETWORK PROVIDERS	WE PAY OUT-OF-NETWORK PROVIDERS
<u>Physician Services</u>		
Physician charges for services in an outpatient Hospital or Clinic, including Surgery, (except Mental Health Services and/or Substance Abuse Care), outpatient lab and X-ray services and all other miscellaneous services	After the Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	After the Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%
Primary Care Physician (PCP) or Specialist (not including Mental Health Services and/or Substance Abuse Care) non-routine/sick office charge for the medical visit only, does not include any lab, X-ray or other	Plans 1 through 6 – 100% after Copayment Plan 7 – 80% after the Deductible Plan 8 – 70% after the Deductible	After the Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%
Physician office charges for all other diagnostic services, including lab, X-ray services (such as chest X-ray and standard plain film X-rays) and the reading/interpretation, Surgery, Second Surgical Opinion, consultation, dialysis treatment, chemotherapy and radiation therapy and Specialty Drugs (including the administration), injections for allergy, tetanus and antibiotics	After the Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	After the Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%
Endoscopies (such as colonoscopy, proctoscopy and laparoscopy) performed in a Physician's office, whether for diagnosis or treatment	After the Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	After the Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%

Schedule of Benefits for Personal BlueSM Basic
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	WE PAY IN-NETWORK PROVIDERS	WE PAY OUT-OF-NETWORK PROVIDERS
High technology diagnostic services such as, but not limited to, MRIs, MRAs, PET scans, CT scans, ultrasounds, cardiac catheterizations, and procedures performed with contrast or dye	After the Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	After the Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%
Inpatient Physician charges for admissions in a Hospital and Skilled Nursing Facility, Surgery, anesthesia, radiology and pathology services	After the Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	After the Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%
<u>Preventive Benefits</u>		
Preventive screenings are covered according to the following: • The United States Preventive Services Task Force (USPSTF) recommended Grade A or B screenings. • Immunizations as recommended by the Center for Disease Control (CDC). • Screenings recommended for children and women by Health Resources and Services Administration	100%	Not Covered
Preventive prostate screening and laboratory work for any Member according to the guidelines of the American Cancer Society	100%	Not Covered
	WE PAY MAMMOGRAPHY NETWORK PROVIDERS	WE PAY OUT-OF-NETWORK PROVIDERS
Preventive mammography screening when provided by a Contracting Mammography Provider	100%	Not Covered
	WE PAY IN-NETWORK PROVIDERS	WE PAY OUT-OF-NETWORK PROVIDERS
<u>Other Services</u>		
Out-of-country services or supplies (including Facility and Physician)	After the Copayment and the Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	After the Copayment and the Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%
Ambulance	After the Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	After the Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%
Home Health Care with the required Preauthorization	After the Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	After the Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%
Inpatient and Outpatient Hospice Care with the required Preauthorization	After the Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	After the Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%
Short-Term Therapy (physical, occupational and speech therapy)	After the Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	After the Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%
Other Therapy Services	After the Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	After the Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%

Schedule of Benefits for Personal BlueSM Basic

(continued)

	WE PAY IN-NETWORK PROVIDERS	WE PAY OUT-OF-NETWORK PROVIDERS
Durable Medical Equipment (DME) – purchase or rental – excludes repair of, replace of and duplicate DME. Preauthorization is required if purchase price or total rental cost is <u>\$500</u> or more.	After the Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	Not Covered
Medical Supplies and Prosthetic Devices	After the Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	After the Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%
Dental Care due to accidental injury to Sound Natural Teeth	After the Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	After the Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%
Mental Health Services and/or Substance Abuse Care	(1) Inpatient/Outpatient – After the Copayment, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70% (2) Physician's Services – After the Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	(2) Inpatient/Outpatient – After the Copayment, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70% (2) Physician's Services – After the Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%
<u>Human Organ and Tissue Transplants</u> When preapproved by us and performed at a Designated Provider, human organ and/or tissue transplant benefits are payable for all expenses for medical and surgical services and supplies while covered under this coverage.	After the Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	After the Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%
<u>Facility Benefits</u>		
Inpatient Hospital (other than Skilled Nursing Facility or Mental Health Services and/or Substance Abuse Care)	After the Copayment and Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	After the Copayment and Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%
Skilled Nursing Facility	After the Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	After the Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%
Inpatient Rehabilitation services when Preauthorized by us	After the Copayment and Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	After the Copayment and Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%
Outpatient Hospital Emergency Room charges. The Copayment is waived if the Member is admitted to the Hospital on the same day and for the same condition.	After the Copayment and Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	After the Copayment and Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%
Outpatient Hospital or Clinic charges for medical and surgical services, preadmission testing, lab and X-ray services and all other miscellaneous services	After the Copayment and Deductible, Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70%	After the Copayment and Deductible, Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50%

Schedule of Benefits for Personal BlueSM Basic

(continued)

Drug Card

	WE PAY CONTRACTING MAIL SERVICE PHARMACY	WE PAY PARTICIPATING NETWORK PHARMACY	WE PAY NON- PARTICIPATING NETWORK PHARMACY
<u>Prescription Drugs</u>			
Drug Card	100% per prescription or refill after you pay the Prescription Drug Copayment of:	100% per prescription or refill after you pay the Prescription Drug Copayment of:	Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50% per prescription or refill after you pay the Prescription Drug Copayment of:
Generic, Preferred and Non-Preferred Drugs	\$16 for Generic Drugs \$70 for Preferred Drugs \$140 for Non-preferred Drugs	\$8 for Generic and designated Over-the-counter Drugs \$30 for Preferred Drugs \$60 for Non-preferred Drugs	\$8 for Generic and designated Over-the-counter Drugs \$30 for Preferred Drugs \$60 for Non-preferred Drugs
	Benefits are limited to a 90-day supply.	Benefits are limited to a 31-day supply or a 90-day supply with 3 Prescription Drug Copayments.	Benefits are limited to a 31-day supply or a 90-day supply with 3 Prescription Drug Copayments.
	Birth control, contraceptives and contraceptive devices are not covered.	Birth control, contraceptives and contraceptive devices are not covered.	Birth control, contraceptives and contraceptive devices are not covered.

If a Physician prescribes a Brand-name Drug for a specific medical reason and marks the prescription dispense as written, then benefits are payable at the Participating Network or Non-Participating Network Pharmacy percentage after the Non-preferred Drug Copayment. If a Physician allows the substitution of a Brand-name Drug and the Member still requests the Brand-name Drug, then the Member must pay Non-preferred Drug Copayment and any difference between the cost of a Generic Drug and the higher cost of a Brand-name Drug.

	WE PAY SPECIALTY DRUG NETWORK PROVIDERS	WE PAY ALL OTHER PHARMACY PROVIDERS
<u>Specialty Drugs</u>	100% prescription or refill after you pay the Specialty Drug Copayment of: 10% not to exceed \$200.	No Benefits

Schedule of Benefits for Personal BlueSM Basic

(continued)

Secure Card

	WE PAY CONTRACTING MAIL SERVICE PHARMACY	WE PAY PARTICIPATING NETWORK PHARMACY	WE PAY NON- PARTICIPATING NETWORK PHARMACY
<u>Prescription Drugs</u>			
Secure Card Generic, Preferred and Non-Preferred Drugs	100% per prescription or refill after you pay the Prescription Drug Copayment of: \$25 for Generic Drugs \$115 for Preferred Drugs \$190 for Non-preferred Drugs Benefits are limited to a 90-day supply. Birth control, contraceptives and contraceptive devices are not covered.	100% per prescription or refill after you pay the Prescription Drug Copayment of: \$10 for Generic and designated Over-the-counter Drugs \$45 for Preferred Drugs \$75 for Non-preferred Drugs Benefits are limited to a 31-day supply or a 90-day supply with 3 Prescription Drug Copayments. Birth control, contraceptives and contraceptive devices are not covered.	No Benefits

If a Physician prescribes a Brand-name Drug and there is an equivalent Generic Drug available (whether or not the Physician marks the prescription dispense as written), then the Member must pay the Non-preferred Drug Copayment and any difference between the cost of the Generic Drug and the higher cost of the Brand-name Drug.

	WE PAY SPECIALTY DRUG NETWORK PROVIDERS	WE PAY ALL OTHER PHARMACY PROVIDERS
<u>Specialty Drugs</u>		
	100% per prescription or refill after you pay the Specialty Drug Copayment of: 20% of Allowable Charges.	No Benefits

Schedule of Benefits for Personal BlueSM Basic
(continued)

Generic Card

	WE PAY CONTRACTING MAIL SERVICE PHARMACY	WE PAY PARTICIPATING NETWORK PHARMACY	WE PAY NON- PARTICIAPTING NETWORK PHARMACY
<u>Prescription Drugs</u>			
Generic Card	100% per prescription or refill after you pay the Prescription Drug Copayment of:	100% per prescription or refill after you pay the Prescription Drug Copayment of:	No Benefits
Generic Drugs	\$20 for Generic Drugs and Diabetic Brand-name Drugs when there is no Generic Drug equivalent (single source Brand-name Drug) Benefits are limited to a 90-day supply. Birth control, contraceptives and contraceptive devices are not covered.	\$10 for Generic and designated Over-the-counter Drugs only and Diabetic Brand-name Drugs when there is no Generic Drug equivalent (single source Brand-name Drug) Benefits are limited to a 31-day supply or a 90-day supply with 3 Prescription Drug Copayments. Birth control, contraceptives and contraceptive devices are not covered.	
	WE PAY SPECIALTY DRUG NETWORK PROVIDERS	WE PAY ALL OTHER PHARMACY PROVIDERS	
<u>Specialty Drugs</u>	No Benefits	No Benefits	

Schedule of Benefits for Personal BlueSM Basic

(continued)

Blue RxSM

	WE PAY CONTRACTING MAIL SERVICE PHARMACY	WE PAY PARTICIPATING NETWORK PHARMACY	WE PAY NON- PARTICIPATING NETWORK PHARMACY
<u>Prescription Drugs</u>			
Blue Rx Generic, Preferred and Non- Preferred Drugs	Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70% per prescription or refill after the Deductible Benefits are limited to a 90-day supply. Birth control, contraceptives and contraceptive devices are not covered.	Plans 1, 3, 5 and 7 pay at 80% Plans 2, 4 and 6 pay at 60% Plan 8 pays at 70% per prescription or refill after the Deductible Benefits are limited to a 31-day supply. Birth control, contraceptives and contraceptive devices are not covered.	Plans 1, 3, 5 and 7 pay at 60% Plans 2, 4 and 6 pay at 40% Plan 8 pays at 50% per prescription or refill after the Deductible Benefits are limited to a 31-day supply. Birth control, contraceptives and contraceptive devices are not covered.

If a Physician prescribes a Brand-name Drug for a specific medical reason and marks the prescription dispense as written, then benefits are payable as indicated above. If a Physician allows the substitution of a Brand-name Drug and the Member still requests the Brand-name Drug, then benefits are payable as indicated above and the Member must pay any difference between the cost of a Generic Drug and the higher cost of a Brand-name Drug.

	WE PAY SPECIALTY DRUG NETWORK PROVIDERS	WE PAY ALL OTHER PHARMACY PROVIDERS
<u>Specialty Drugs</u>	100% per prescription or refill after you pay the Specialty Drug Copayment of: 10% not to exceed \$200	No Benefits

Schedule of Benefits for Personal BlueSM Basic

(continued)

Basic Card

	WE PAY CONTRACTING MAIL SERVICE PHARMACY	WE PAY PARTICIPATING NETWORK PHARMACY	WE PAY NON- PARTICIPATING NETWORK PHARMACY
<u>Prescription Drugs</u>			
Basic Card Generic, Preferred and Non-Preferred Drugs	100% per prescription or refill after you pay the Prescription Drug Copayment of: \$25 for Generic Drugs (Tier 1) \$115 for Preferred Drugs (Tier 2) \$190 for Non-preferred Drugs (Tier 3) Benefits are limited to a 90-day supply. Birth control, contraceptives and contraceptive devices are not covered.	100% per prescription or refill after you pay the Prescription Drug Copayment of: \$15 for Generic and designated Over-the-counter Drugs (Tier 1) \$60 for Preferred Drugs (Tier 2) \$75 for Non-preferred Drugs (Tier 3) Benefits are limited to a 31-day supply or a 90-day supply with 3 Prescription Drug Copayments. Birth control, contraceptives and contraceptive devices are not covered.	No Benefits

If a Member requests a Brand-name Drug (whether or not the Physician marks the prescription as dispense as written) and that drug has a generic equivalent, then the Member will pay 100% of the cost for that drug. Prescription Drugs available in the lower Tier, beginning with Generic Drugs, must have been tried before benefits will be available for each higher Tier.

	WE PAY SPECIALTY DRUG NETWORK PROVIDERS	WE PAY ALL OTHER PHARMACY PROVIDERS
<u>Specialty Drugs</u>		
	100% per prescription or refill after you pay the Specialty Drug Copayment of: 50% of Allowable Charges.	No Benefits

Schedule of Benefits for Personal BlueSM Basic
(continued)

Optional Benefits – These benefits are included in this Policy only if indicated.

Dental and Vision Coverage

Dental and Vision Coverage Purchased or Not Purchased

Dental Coverage

We pay for covered dental services based upon the Allowable Charge for that service. The Allowable Charge is the total amount eligible for payment by Blue Cross. The Allowable Charge may be subject to Coinsurance.

Benefits for dental services are limited to \$300 for per Member per Benefit Period. All covered dental services apply to the \$300 maximum payment.

<u>Covered Service</u>	<u>Percentage of Allowable Charges Payable</u>
Class 1	100%
Class 2 - Does not include the removal of impacted teeth	50%

Vision Benefits

<u>Covered Service</u>	<u>Payment</u>
Eye exam, limited to one exam per Member per Benefit Period	\$100
Frames, lenses and/or contact lenses (combined) per Member per Benefit Period	\$50

Accident Medical Expense

Accident Medical Expense Purchased or Not Purchased

<u>Covered Service</u>	<u>Percentage of Allowable Charges Payable</u>
Covered Services due to an accident	100% of the first \$500

Benefits for accidental injury are limited to \$500 per Member per Benefit Period. Amounts over \$500 are payable under the regular Policy benefits and are subject to the Deductibles, Copayments and Coinsurance.

Maternity Care

Maternity Purchased or Not Purchased

Benefits will be provided due to a Pregnancy as shown in the Maternity Schedule. Benefits are not subject to Deductibles, Copayments or Out-of-pocket Maximums.

<u>Period of Time</u>	<u>Percentage of Allowable Charges Payable</u>
Charges incurred during the first 12 months of coverage	5%
Charges incurred during the 13 th month through 24 th month of coverage	60%
Charges incurred during the 25 th month through 36 th month of coverage	80%
Charges incurred during or after the 37 th month of coverage	100%

**PERSONAL BLUESM BASIC
MAJOR MEDICAL EXPENSE COVERAGE WITH LIMITED BENEFITS FOR
HUMAN ORGAN AND/OR TISSUE TRANSPLANTS**

Guaranteed Renewable Except for Stated Reasons

You may renew this 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, rescind or issue a Rider to the Policy:

1. If you don't pay the premiums according to the terms of the Policy or if we have not received timely premium payments; or
2. If you commit fraud, make a false statement or omission or misrepresent a fact, whether intentional or not, in the application which was material to us in deciding to issue the Policy; or
3. If we decide to discontinue offering Personal Blue Basic for everyone who has this Policy. However, we may only discontinue coverage if we:
 - a. Provide notice to each individual covered by this Policy of the discontinuance at least 90 days before the date the Policy is discontinued;
 - b. Offer to each individual covered by this Policy the option to purchase other individual Health Insurance coverage we currently offer; 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 offer the option to purchase other individual coverage.
4. At the time of renewal, we may modify this 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 your physical or mental health changes or your Dependents' physical or mental health change after your Policy's Effective Date.

Premium Rate Subject to Change

We base initial premiums on the age of each covered Member at the time you are issued this Policy. The Schedule of Benefits that is included with the Policy shows the current premiums. Premiums will change when each Member's age changes and may change if you change your place of residence. We may also change premium rates if we take the same action on all policies issued with the same form number. In this case, we will notify the Policyholder of the new premium rate at least 31 days before the next premium due date.

Right to Examine Policy for 30 Days

If you are not satisfied with this Policy, you must notify us in writing and return it to us or our agent within 30 days after you receive it. We will return all premiums minus any claims paid. If the Policy is returned, it will be void from the Effective Date.

Important Notice Concerning Statements in Your Application for Insurance

The application is a part of your Policy. Your application will be mailed to you separately. We issued the insurance Policy on the basis that the answers to all questions and any other material information shown on the application are correct and complete and that your health did not change between the time you signed your application and the effective date of this Policy. You have a duty to disclose updated medical and personal information from the date of the application until the Effective Date of the Policy. If an error on your application misled us about the risk we assumed, we may have grounds to rescind the Policy or issue a Rider that may limit or exclude certain conditions or persons, subject to the Time Limit on Certain Defenses provision. If the Policy is rescinded, we will refund your premiums minus any claims paid. No agent, employee or representative of Blue Cross and Blue Shield of South Carolina has the authority to waive or change any of the requirements within the application or waive or change any of the provisions within this Policy.

Please read the copy of the application. If any information on it is not correct and complete as of the date this Policy was issued, or if any medical history has not been included, write to Blue Cross and Blue Shield of South Carolina, Individual Membership Department, Post Office Box 61153, Columbia, South Carolina, 29260 within 10 days. Failure to provide correct and complete medical and personal information in the application may result in rescission of the Policy, or the issuance of a Rider that may limit or exclude certain coverage. After this Policy has been in force for two years, we can't use any statement made in any application (unless fraudulent) to void the Policy or deny any claim incurred after the two-year period according to the Time Limit on Certain Defenses provision.

BLUE CROSS[®] AND BLUE SHIELD[®] OF SOUTH CAROLINA

www.SouthCarolinaBlues.com



**James A. Deyling
President**

BlueCross BlueShield of South Carolina Division

This Policy contains a requirement for Preauthorization and Approval of certain services, including Mental Health Services and Substance Abuse care. See the *Preauthorization and Approval* section of this Policy for details. If you or your Physician doesn't get proper Preauthorization and Approval, Allowable Charges may be subject to a benefit payment reduction or non-payment.

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A. GENERAL

Introduction

This Policy explains the benefits available to you from Blue Cross and Blue Shield of South Carolina.

As you refer to this Policy, please note that the words beginning with **capital letters** have special definitions. We have included the definitions of these terms in *Section G* to help you understand your Policy.

To make sure your claims are handled properly, our process involves evaluation and Preauthorization of certain services, all admissions (at least 48 hours prior to services), Emergency/Urgent admissions and Continued Stay Services (ongoing care exceeding initial care Preauthorization). Early identification and management of health problems can help reduce health care costs.

Preauthorization and Approval is required in advance for certain services in order to receive maximum benefits available under this Policy. **Failure to obtain Preauthorization and Approval may result in non-payment or reduction in benefit payment. Preauthorization and Approval does not constitute our agreement or guarantee to pay for the requested services. All of the terms, conditions, exclusions and limitations of the Policy apply to a claim submitted for payment after Preauthorization and Approval has been given. Payment can only be determined upon review of the Policy when a claim is submitted by a Physician or Provider, along with any accompanying medical records.**

How to Contact Us

It's only natural to have questions about your coverage and Blue Cross is committed to helping you understand your Policy so you can make the most of your benefits.

For Customer Service Inquiries:

If you have any questions about your eligibility, changes to your Policy or rates, please contact the Individual Membership department. We can be reached by telephone, mail or through our Web site.

Telephone Numbers: (Monday through Friday, 8:30 a.m. to 5:30 p.m. Eastern Standard Time)

(803) 264-6401 (from the Columbia area)
1-800-868-2500, ext. 46401 (from all other areas)

Mailing Address:

Individual Membership
Blue Cross and Blue Shield of South Carolina
P.O. Box 61153
Columbia, SC 29260

Web Site Address:

www.SouthCarolinaBlues.com, then log in to "My Insurance Manager^{SMT}."

For Health Claim Inquiries:

If you have any questions about your claims, please contact the Claims Service Center. We can be reached by telephone, mail or through our Web site. You also can find the mailing address on the back of your Blue Cross identification (ID) card.

Telephone Numbers: (Monday through Friday, 8:30 a.m. to 5:30 p.m. Eastern Standard Time)

(803) 264-3475 (from the Columbia area)
1-800-868-2500, ext. 43475 (from all other areas)

Mailing Address:

Claims Service Center
Blue Cross and Blue Shield of South Carolina
P.O. Box 100300
Columbia, SC 29202

Web Site Address:

www.SouthCarolinaBlues.com, then log in to "My Insurance Manager."

For Preadmission Reviews and Preauthorizations:

Please refer to the *Preauthorization and Approval* section of this Policy for a detailed list of the services and supplies that require Preadmission Review and Preauthorization.

For MRIs, MRAs, CT Scans or PET Scans in an Outpatient Facility or a Physician's Office, call National Imaging Associates at:

1-866-500-7664.

For Preadmission Review or Preauthorization for all other medical care, please call:

<u>(803) 736-5990</u>	(from the Columbia area)
<u>1-800-327-3238</u>	(from all other South Carolina locations)
<u>1-800-334-7287</u>	(from outside South Carolina)

For Preadmission Review and Preauthorization of Mental Health Services and/or Substance Abuse care, call Companion Benefit Alternatives, Inc. (CBA) at:

<u>(803) 699-7308</u>	(from the Columbia area)
<u>1-800-868-1032</u>	(from all other areas)

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.

On behalf of Blue Cross and Blue Shield of South Carolina, National Imaging Associates, provides utilization management services for certain radiological procedures. National Imaging Associates is a separate company.

Your Fastest Place for Answers – www.SouthCarolinaBlues.com

If you have access to the Internet you can find quick and easy answers to your health coverage questions any time day or night. When you go to www.SouthCarolinaBlues.com, you'll find useful tools that can help you better understand your coverage.

Here are some of the things you can do on our Web site:

- Learn more about our products and services.
- Stay informed with all the latest Blue Cross news, including press releases and legislative issues.
- Find links to other health-related Web sites.
- Locate a network Physician, Hospital or Pharmacy.
- Use My Insurance Manager.

My Insurance Manager

You can get to "My Insurance Manager" from www.SouthCarolinaBlues.com to:

- Check your eligibility.
- See how much you've paid toward your Deductible or Out-of-pocket Maximum.
- Check on Authorizations.
- Find out if we've processed your claims.
- Order a new ID card.
- See if our records show if you have other Health Insurance.
- Ask a Customer Services representative a question through secure e-mail.
- View your Explanation of Benefits (EOB).

When Your Coverage Begins and Ends

Eligibility: This Policy is available to you and your spouse if you are both under age 64½ and live in South Carolina. Your dependent children may also be eligible for coverage if they are under age 19, or under age 23 if a Full-time Student at the time you apply for coverage. Proof of health is required for a spouse and child unless the child is a newborn or is adopted and an application and any premium that may be due is submitted within 31 days of birth or adoption.

Insurance coverage will be effective at 12:01 a.m. Eastern Standard Time on the Effective Date shown on the Schedule of Benefits.

Adding a Child: If you or your spouse gives birth or a child is placed with you or your spouse for the purpose of adoption while this Policy is in force for you, then the child is covered from the moment of birth or adoption for Medically Necessary Covered Services and supplies, but only if you submit an application and any premium that may be due within 31 days of the birth or adoption. For newborns enrolled within 31 days of birth and newly adopted children enrolled within 31 days of eligibility, this includes any necessary care and treatment of medically diagnosed birth defects, diseases and anomalies or complications due to a premature birth. Failure to send us a completed application within 31 days of the birth or adoption will result in no coverage for that Dependent child.

For an adopted child, coverage will start when you pay the appropriate premium, if any, as follows:

1. From the moment of birth for a child you or your spouse legally adopts within 31 days of the date of the child's birth;
2. From the moment of birth for a child for whom you or your spouse has temporary custody and have begun adoption proceedings within 31 days of the child's birth; or
3. When the adopted child is not a newborn, upon temporary custody with you or your spouse. Coverage will continue as long as you or your spouse has custody of the child.

To add any other Dependent child as a Member, you must: 1) submit an application for our approval, and 2) pay any additional premium that may be required. We will require proof of the child's good health. The child won't become a Member until we receive any required premium and we give you written notice of our approval.

Termination of Insurance: Your coverage will end at 12:01 a.m. Eastern Standard Time: 1) on the next premium due date after we receive your request in writing, or 2) on the date the Policy lapses due to non-payment of premiums, is non-renewed or is rescinded, whichever occurs first. In the event of termination of this Policy, coverage terminates for you, your covered spouse and any covered dependents.

In the event of your death, your spouse or a Dependent child, if covered under the Policy, will become the Policyholder.

We will pay benefits to the end of the period for which we accepted premiums.

Termination of Insurance for Your Covered Spouse: Your Spouse's coverage will end at 12:01 a.m. Eastern Standard Time: 1) on the next premium due date after we receive your request in writing, 2) on the date the Policy lapses due to non-payment of premiums or is non-renewed, or 3) on the premium due date following the date of a divorce, whichever occurs first.

We will pay benefits to the end of the period for which we accepted premiums.

Termination of Insurance for Your Other Covered Dependents: Coverage will end for a child at 12:01 a.m. Eastern Standard Time on the earlier of:

1. The next premium due date after we receive your request in writing;
2. The date the Policy lapses due to non-payment of premiums or is non-renewed; or
3. The premium due date following:
 - a. The date of his or her marriage;
 - b. The date he or she reaches age 19, or reaches age 23 if a Full-time Student; or
 - c. The date he or she is no longer financially dependent upon you.

Once a Dependent child has been married, he or she is not eligible for coverage again as a Dependent child on this Policy.

An Incapacitated child's coverage, however, will not end simply because he or she has reached age 19 or age 23 if a Full-time Student.

We will pay benefits to the end of the period for which we accepted premiums.

Continuation of Coverage for Your Former Spouse and Non-Incapacitated Dependent Children: If a spouse covered under this Policy is no longer eligible because of a legal divorce, or if a non-Incapacitated Dependent child covered under this Policy is no longer eligible because of reaching the age limit, then they may obtain a similar policy from us without proof of good health, but only if:

1. The spouse sends us written notification and the required premium within 60 days after the legal divorce; or
2. The non-Incapacitated Dependent child sends us written notification and the required premium within 30 days after reaching the age limit.

The new policy will provide coverage from us similar to, but not greater than, this coverage. The premium will apply to the age of such Member at the time of continuation. The new policy Effective Date will be the date coverage ceased for such Member under this Policy provided items 1 or 2 above are met.

Any exclusion or limitation Riders on this Policy will be carried forward to the new policy.

Extension of Benefits After Termination of Coverage: In the event your Policy is terminated or not renewed, coverage may be extended for any Member if that person is in the Hospital, Skilled Nursing Facility or is Totally Disabled on the day coverage ends. The Member's coverage will continue while the Member remains Totally Disabled from the same or related cause until one of these occurs: 1) the date the hospitalization ends or the date of recovery from the Total Disability, whichever is later; or 2) the Policy maximums are met; or 3) 12 months from the termination date. We will pay benefits only for Covered Services as listed in this Policy that are related to the treatment of the disabling medical condition.

The terms Totally Disabled/Total Disability mean the Member 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 unable to perform the normal activities of a child in good health of the same age and sex.

Important Note: We recommend that you notify us if you wish to exercise the Extension of Benefits rights. We will then determine if the Member is eligible for benefits. In order for us to recognize Extension of Benefits and ensure proper payment, claims must include a Physician's statement of disability.

Cancellation: You may cancel this Policy at any time by written notice delivered or mailed to us. The cancellation will be effective on the next premium due date after we receive your request in writing. Even if requested, we will not cancel this Policy retroactively and refund any premium, whether or not you had any claims during that period of time.

Deductible, Out-of-pocket Maximum and Maximum Payments

Deductible per Policy: The Deductible is shown on the Schedule of Benefits and on your application. If this Policy provides coverage on a family basis, each Member will contribute to the Deductible until the Deductible has been met.

You may have a separate Prescription Drug Deductible for the Prescription Drug coverage. Your Schedule of Benefits will show if you have a separate Prescription Drug Deductible. Charges or amounts you pay towards the Prescription Drug Deductible will not be applied to satisfy any other Deductible and the Deductible will not apply to the Prescription Drug Deductible.

You may also have a separate Specialty Drug Deductible, if Specialty Drug coverage is provided under the Prescription Drug benefits. Your Schedule of Benefits will show if you have Specialty Drug benefits included in the Prescription Drug benefits. If the Prescription Drug coverage includes a Specialty Drug Deductible, it will not apply to the Deductible or the Prescription Drug Deductible (if any). And the Deductible and Prescription Drug Deductible (if any) will not apply to the Specialty Drug Deductible.

Out-of-pocket Maximum: A maximum amount of Coinsurance that you must pay for Covered Services during a Benefit Period. The Out-of-pocket Maximum is made up of the Coinsurance amounts payable by you. It doesn't include any Deductibles, Copayments and Coinsurance for certain services as indicated in the Schedule of Benefits. For a Single Policy, when a Member reaches his or her Out-of-pocket Maximum, we will increase the payment as shown in the Schedule of Benefits. For a Family Policy, when the family reaches the family Out-of-pocket Maximum, we will increase the payment as shown in the Schedule of Benefits. However, the payment **won't be** increased for those benefits shown in the Schedule of Benefits when the Out-of-pocket Maximum has been reached. Payment will also not be increased if the Policy has an unlimited Out-of-pocket Maximum.

The Out-of-pocket Maximum is shown on the Schedule of Benefits and on your Application. The In-network Provider Out-of-pocket Maximum doesn't apply to the Out-of-network Provider Out-of-Pocket Maximum.

Benefit Period Maximum and Lifetime Maximum: The Benefit Period Maximum is shown on the Schedule of Benefits. The Lifetime Maximum is shown on the Schedule of Benefits. The Lifetime Maximum is reduced by the Lifetime Maximum payment for Inpatient Rehabilitation, Transplants and Mental Health Services and/or Substance Abuse care.

Preferred Blue Providers (In-network Providers)

The backbone of this Policy is the independent network of **Preferred Blue Providers**. These Physicians, Hospitals, Skilled Nursing Facilities, home health agencies, hospices and other Providers have agreed to provide health care services to Blue Cross and Blue Shield of South Carolina Members at a discounted rate.

Your benefits will be paid at a higher percentage when you receive medical, surgical, Mental Health Services and/or Substance Abuse care from a Preferred Blue Provider.

Your In-network Provider has agreed to:

- Bill you no more for Covered Services than the Blue Cross Preferred Blue network allowance.
- File all claims for Blue Cross covered services for you.
- Ask you to pay only the required Deductibles, Copayments and Coinsurance for covered amounts.

To find out if your Physician or Hospital is a Preferred Blue Provider, you can check the Preferred Blue Provider directory. You can call the Claims Service Center toll-free at [1-800-868-2500](tel:1-800-868-2500), ext. 43475 or in the Columbia area at [803-264-3475](tel:803-264-3475) and request a directory. Or visit our Web site at www.SouthCarolinaBlues.com. Since the Preferred Blue Provider network changes all the time, it's a good idea to ask your Physician or Hospital if it is a Preferred Blue Provider before you receive care.

To ensure you receive all of the benefits you're entitled to, be sure to show your ID card whenever you visit your Physician or Hospital. This way your Provider will know you have this coverage.

Please note that you may be seen in a teaching facility or by a Provider who has a teaching program. This means that a medical student, intern or resident participating in a teaching program may see you. Please ask your Provider if you have questions about your care.

Out-of-network Providers (All Other Providers)

Not all Physicians, Hospitals and other health care Providers have contracted with Blue Cross and Blue Shield of South Carolina to be Preferred Blue Providers. Those who have not are called **Out-of-network Providers**. Blue Cross makes every effort to contract with Physicians who practice at Preferred Blue Hospitals. Some Physicians, however, choose not to be Preferred Blue Providers even though they may practice at Preferred Blue Hospitals. Although this Policy gives you the freedom to use an Out-of-network Provider, the percentage of benefits we pay will be lower. This means you pay more money out of your own pocket. Out-of-network Provider Benefit percentages are shown on your Schedule of Benefits.

We encourage you to use In-network Providers whenever you can for a number of reasons. Out-of-network Providers may:

- Require you to pay the full amount of their charges at the time you receive services.
- Require you to file your own claims.
- Require you to get all necessary Approvals. Information regarding how and when to get an Approval is in the *Preauthorization and Approval* section.
- Charge you more than the Blue Cross Allowed Charge.

How to File Claims

If you receive health care services or supplies from an In-network Provider, the Provider will file your claims for you.

If you receive health care services or supplies from an Out-of-network Provider or non-Contracting Provider, you'll have to file your own claims. Please follow the instructions below when you have claims for expenses other than Prescription Drugs. When filing your own claims, here are some things you'll need:

1. **Comprehensive Benefits Claim Form for each patient.** You can get these forms from the Claims Service Center or from our Web site at www.SouthCarolinaBlues.com.
2. **Itemized Bills From the Providers.** These bills should include:
 - a. Provider's name and address
 - b. Patient's name and date of birth
 - c. Policyholder's Blue Cross ID number
 - d. Description and cost of each service
 - e. Date that each service took place
 - f. Description of the illness or injury (diagnosis)

Complete the front of each claim form and attach the itemized bills to it.

Before you submit your claims, we suggest you make copies of all claim forms and itemized bills for your records since we can't return them to you. Send your claims to the Claims Service Center at the address found in the *How to Contact Us* section.

How to File a Claim for Prescription Drugs Purchased at a Non-Contracting Pharmacy (if this Policy provides benefits for non-Contracting Pharmacies): To file your claim for Prescription Drugs:

1. Use a Prescription Drug claim form. You can get these forms from the Claims Service Center or from our Web site at www.SouthCarolinaBlues.com.
2. Fill out the top half of the form, sign it and attach the receipt for the Prescription Drugs.
3. Mail the form to the Contracting Pharmacy Benefit Manager at the address shown on the form.

How Long You Have to File a Claim: We must receive your claim, Provider's bill and/or receipt no later than 12 months from the end of the Benefit Period in which you received the services or supplies. Exception is made if you show you were not legally competent to file the claim.

B. DEFINITIONS

Accidental Injury: An injury directly and independently caused by a specific accidental contact with another body or object. The injury must occur while you're covered under this Policy. All injuries you receive in one accident, including all related conditions and recurrent symptoms of these injuries, will be considered one injury. Accidental Injury doesn't include indirect or direct loss that results in whole or partially from a disease or other illness.

Allowable Charge: The Allowable Charge for Preferred Blue Providers is an allowance mutually agreed upon by Preferred Blue Providers and Blue Cross. For Out-of-network Providers, the Allowable Charge will be the actual charge submitted to us or the Maximum Payment, whichever is less.

The Maximum Payment is the total amount eligible for payment by us for the services, supplies or equipment you receive from a Provider. The Maximum Payment that we determine will be the least of 1, 2, 3, 4 or 5:

1. The Providers' actual charges for similar services, supplies or equipment filed with us during the last calendar year.
2. The Maximum Payment for the last year increased by an index based on national or local economic factors or indices.
3. The lowest charge level at which any medical services, supplies or equipment is generally available in the area, when in our judgment, a charge for such services, supplies or equipment should not vary significantly from one Provider to another.
4. A set of allowances that has been mutually agreed upon by Contracting Providers and Blue Cross.
5. A set of allowances established by us.

Review of the Maximum Payment will occur following each calendar year. If there are no actual or similar charges, as referred to above, we may, through our medical staff and/or consultants, determine the Maximum Payment based on comparable or similar services or procedures.

Allowable Charges may be subject to a Deductible, Copayment and Coinsurance, as shown in your Schedule of Benefits.

Benefit Period: The Benefit Period begins on the Effective Date of your coverage under the Policy and lasts 365 days except for leap year. Then a new Benefit Period will begin. Your Benefit Period is shown on your Schedule of Benefits.

Benefit Period Maximum: The Benefit Period Maximum is the maximum amount for Covered Services we will pay per Member per Benefit Period.

Clinic: An Outpatient Facility for examining and treating patients who aren't bedridden. It must be operated under the supervision of a Physician. A Clinic includes an endoscopy center. The Clinic must not be used for the private practice of a Physician.

Coinsurance: The percentage of Allowable Charges you pay as your share of Covered Services. This percentage applies to the negotiated rate or lesser charge when we have negotiated rates with that Provider. Coinsurance applies to the Out-of-pocket Maximum (if this Policy has an Out-of-pocket Maximum) unless indicated on your Schedule of Benefits.

Contracting Mammography Provider: A Provider contracting with us in writing to provide routine mammograms. Please note that this is a separate list of Providers specifically for mammograms.

Contracting Provider: Any Provider contracting with us in writing to provide services at an agreed upon rate (may include Preferred Blue Providers and/or Mammography Providers).

Copayment: A fee you pay each time you receive a certain service or supply such as a doctor's office visit, a particular medical service, Hospital admission or prescription. Copayments are shown on the Schedule of Benefits. Copayments don't go toward reaching your Deductible or Out-of-pocket Maximum. You will continue to be responsible for Copayments even after you meet your Deductible and reach your Out-of-pocket Maximum (if this Policy has an Out-of-pocket Maximum).

Cosmetic Surgery: Any plastic or reconstructive Surgery done mainly to improve the appearance or shape of any body part and for which no improvement in physiological or body function is reasonably expected. Cosmetic Surgery includes, but is not limited to, Surgery for saggy or extra skin (regardless of reason); any augmentation, reduction, reshaping or injection procedures of any part of the body; rhinoplasty, abdominoplasty, liposuction and other associated types of Surgery; and any procedures using an implant that doesn't alter physiologic or body function or isn't incidental to a surgical procedure.

Covered Service: Medically Necessary treatment, care services or supplies a Physician prescribes for the treatment and diagnosis of an illness or injury. Covered Services are subject to all provisions of this Policy, which include *Exclusions and Limitations*, *Pre-existing Condition Limitation and Exclusion* and *Preauthorization and Approval*. The Deductible, Coinsurance and other limitations shown in your Schedule of Benefits also apply.

Creditable Coverage: Health coverage under any public or private insurance plan, as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You receive coverage under this policy that will reduce any period of pre-existing condition exclusion if, in the future, you are covered under a group health plan or the South Carolina Health Insurance Pool (SCHIP), so long as there is no more than a 63-day break in coverage between this plan and the coverage listed above. However, you do not receive credit for any prior coverage when coming to this policy because of different laws and regulations that apply to individual health insurance coverage. You may have a period of pre-existing condition limitation, you may receive a rider for a condition that will not be covered for some period or indefinitely.

When your coverage under this Policy ends, you have the right to receive a certification showing the period of coverage you had under this Policy. This period of coverage is called Creditable Coverage. You may also request the Certificate of Creditable Coverage from us even if your coverage is still in force. To request the Certificate of Creditable Coverage, please write or call the Individual Membership department at the address or phone number listed in the *How to Contact Us* section.

Custodial Care: Care that we determine is provided primarily to assist the patient in the activities of daily living and doesn't require a person with medical training to provide the services. Custodial Care includes, but is not limited to, help with activities of daily living, walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administered medications.

Deductible: The amount of Allowable Charges you are responsible for paying each Benefit Period before benefits are payable on a claim for Covered Services. The Deductible applies to all Covered Services unless otherwise noted. The Deductible doesn't apply to the Out-of-pocket Maximum (if this Policy has an Out-of-pocket Maximum). The Deductible is shown in the Schedule of Benefits. You may have separate Deductibles for your Prescription Drug Coverage (if provided under this Policy) Specialty Drug Coverage (if provided under this Policy) and for Out-of-network Providers.

Dependent(s): Your spouse and/or unmarried children through age 18 or age 22 if a Full-time Student who are covered under this Policy. Dependent children are natural or adopted children stepchildren, foster children or children who are under your legal guardianship or for whom a court order requires you to provide Health Insurance. Children must qualify as a dependent of you or your spouse under the United States Revenue Code and federal tax regulations.

Designated Provider: Any Provider we require you to use for specialized services in order to receive benefits for these services. These Providers include, but are not limited to, Contracting Mammography Providers. We won't pay benefits unless a Designated Provider performs these services.

Durable Medical Equipment: Equipment your doctor orders that has exclusive medical use. These items must be reusable and may include wheelchairs, hospital-type beds, walkers, Prosthetic Devices, oxygen, respirators, etc. To qualify for benefits, your Physician must order the medical equipment and it must be Medically Necessary for a specific need. Equipment such as air conditioners, whirlpool baths, spas, (de)humidifiers, wigs, fitness supplies, vacuum cleaners or air filters don't qualify because they don't have exclusive medical uses. To be considered Durable Medical Equipment, the device or equipment's use must be limited to the patient for whom it was ordered. This means others can't use the device or equipment.

Effective Date: The date on which coverage for a Member begins under this Policy.

Emergency Medical Care: Health care services provided in a Hospital emergency room to evaluate and treat an Emergency Medical Condition.

Emergency Medical Condition: An illness or injury so severe that a reasonable person with an average knowledge of health and medicine could reasonably expect that if he or she doesn't get medical care right away, one of these might occur:

1. Serious risk to one's health. If a woman is pregnant, this includes her health or her unborn child's health; or
2. Serious damage to organs, body functions or body parts.

Facility: A Hospital, Skilled Nursing Facility, ambulatory surgical center or Clinic.

Full-time Student: A Dependent child age 22 or younger and enrolled in and attending one of these:

1. High school; or
2. An accredited or licensed school commonly recognized as a vocational, technical or trade school, with attendance qualifying the Dependent child as a full-time student under the rules of the institution; or
3. A college or university with full enrollment in at least enough regular academic courses to reach the status of a full-time student at the institution.

Periods between school terms, such as summer periods, will be included if the child was attending as a Full-time Student during the last regular school term or session. Correspondence-course participation doesn't count as attendance as a Full-time Student.

A time period between graduation from high school and vocational, technical or trade school or college entry, or between college graduation and graduate school entry will be included only if the child has applied for admission beginning with the next regular school term or session immediately following graduation.

You must send us a letter stating the Dependent child is a Full-time Student. Your letter must include a tuition receipt from the school's Bursar's office or a letter from the school verifying its accreditation and the student's full-time status.

Genetic Information: Information about genes, gene products or genetic characteristics (hair and eye color, risks for certain diseases, etc.) that are passed down from parents to children. "Gene product" is a scientific term that means messenger RNA and translated protein. Genetic Information doesn't include: routine physical measurements; chemical, blood and urine analysis, unless purposely done to diagnose a genetic characteristic; tests for abuse of drugs; and tests for the presence of HIV.

Health Insurance (Other Policies): A Policy that provides insurance, reimbursement, or service benefits for Hospital, surgical or medical costs. This includes, but is not limited to, coverage under: 1) individual or group insurance policies; 2) nonprofit health service plans; 3) health maintenance organization (HMO) subscriber contracts; 4) preferred provider organization (PPO) subscriber contracts; 5) self-insured group plans; 6) prepayment plans; 7) Medicare; and 8) any state or federal mandated Health Insurance plan.

Health Status-related Factor: Any one of these: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, Genetic Information, evidence of insurability, conditions arising out of acts of domestic violence, or disability.

Home Health Care: Care you get in your home that you would normally receive during an Inpatient Admission. You must receive Home Health Care from a home health agency that is licensed by the state in which it operates. We must approve benefits for Home Health Care in advance.

Hospice Care: A program of care for terminally ill people who aren't expected to live more than six months. It must be provided in lieu of Inpatient care at a Hospital or Skilled Nursing Facility to a patient who would otherwise need Inpatient care. Hospice Care requires Preauthorization Review.

Hospital: A short-term, acute-care Facility that:

1. Is licensed and operated according to the law; and
2. Primarily and continuously provides or operates medical, diagnostic, therapeutic and major surgical Facilities for the medical care and treatment of injured or sick people on an Inpatient basis. It must also be under the supervision of a staff of duly licensed Physicians; and
3. Provides 24-hour nursing services by or under the supervision of registered nurses (RNs).

The term Hospital doesn't include long-term, chronic-care institutions or institutions that are, other than incidentally:

1. Convalescent, rest or nursing homes or Facilities; or
2. Facilities primarily affording custodial, educational or rehabilitative care; or
3. For the treatment of substance or alcohol abuse; or
4. For the treatment of mental or nervous conditions.

The term Hospital doesn't include a long-term, chronic-care institution or Facility which mainly provides care for items 1 through 4 above, whether or not such institution or Facility is affiliated with or part of a Hospital.

Incapacitated Dependent Child: The limiting age doesn't apply to an unmarried child who becomes and continues to be: 1) incapable of self-sustaining employment because of mental or physical handicap or disability; and 2) mainly dependent upon the Policyholder or Policyholder's spouse for support and maintenance. The child must have developed the handicap or disability before he or she reached the age at which coverage would otherwise terminate. To keep coverage for an Incapacitated Dependent child you must give us written proof of the disability from a Physician within 31 days of the Dependents 19th birthday or 23rd birthday if a Full-time Student. For the child to remain covered, we must receive a Physician's written report every two years within 31 days of the child's birthday. If your coverage ends for any reason, coverage for an Incapacitated Dependent Child will also end.

Inpatient: A Member who is a registered bed patient in a Hospital, Skilled Nursing Facility, Rehabilitation Facility or Psychiatric/Substance Abuse Facility, who is charged room and board for the stay.

Investigational or Experimental: The use of treatments, procedures, facilities, equipment, drugs, devices, services or supplies (herein collectively referred to as a "service") that we don't recognize as standard medical care for the treatment of conditions, diseases, illnesses or injuries. We may use the following criteria to determine whether a service is Investigational or Experimental:

1. The service requires Federal or other governmental agency approval such as drugs and devices that have restricted market approval from the Food and Drug Administration (FDA) or from any other governmental regulatory agency for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.

We will, however, allow coverage for a Prescription Drug that hasn't been approved by the FDA:

- a. For a specific medical condition when there are at least two formal clinical studies recognizing the use of the drug for the medical condition; or
 - b. For the treatment of a specific type of cancer, provided the Prescription Drug is recognized for the treatment of that specific cancer in at least one standard reference compendium or the drug is found to be safe and effective in formal clinical studies. These results must have been published in peer-reviewed professional medical journals.
2. There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to let us evaluate the therapeutic value of the service.
 3. There is inconclusive evidence that the service has a beneficial effect on a person's health.
 4. The service under consideration is not as beneficial as any established alternatives.
 5. There is insufficient information or inconclusive scientific evidence that the service is beneficial to the person's health and is as beneficial as any established alternatives when used in a noninvestigational setting.

If a service meets one or more of these criteria, it is Investigational or Experimental. We solely make these determinations after independent review of scientific data. We may also consider opinions of professionals in a particular field and/or opinions and assessments of nationally recognized review organizations, but they are not determinative or conclusive.

Our Medical Director, in making such determinations, may consult with or use one or more of these sources of information:

1. FDA-approved market rulings;
2. *The United States Pharmacopoeia and National Formulary*;
3. The annotated publication titled, *Drugs, Facts, and Comparisons*, published by J. B. Lippincott Company;
4. Available peer review literature; and
5. Consultation with professionals and/or specialists on a local and national level.

Legal Guardian: The guardian of a minor child other than an institution or agency appointed by a court of any state.

Legally Intoxicated: The Member's blood alcohol level was at or in excess of legal limits under applicable state law, when measured by law enforcement or medical personnel.

Lifetime Maximum: The Lifetime Maximum is the maximum amount for Covered Services that we will pay for each Member while covered under this Policy during the Member's lifetime. The Lifetime Maximum Payment includes the Lifetime Maximum Payment for Inpatient Rehabilitation, the Transplant Lifetime Maximum and Mental Health Services and/or Substance Abuse care.

Medicaid: Cooperative federal-state programs providing medical assistance and other services to certain classes of financially needy persons as established by Title XIX of the Social Security Act of 1965, as amended.

Medical Supplies: Syringes and related supplies for conditions such as diabetes, dressings for conditions such as cancer or burns, catheters, test tape, necessary kidney (renal) supplies and surgical trays. Supplies and equipment that have non-therapeutic uses, over-the-counter supplies and bandages are not covered medical expenses.

Medically Necessary: Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
3. Not primarily for the convenience of the patient, Physician or other health care Provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Medicare: The program of health care for the aged, disabled and individuals with end stage renal disease established by Title XVIII of the Social Security Act of 1965, as amended.

Member: A person insured by this Policy. If the Member is under age 18 at the time this Policy is issued, a parent or Legal Guardian must have applied for coverage on behalf of the Member and is responsible for payment of all premiums.

Mental Health Services: Treatment of mental and nervous conditions or other conditions. These conditions are defined, described or classified as psychiatric disorders or conditions in the publication of The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*. Substance Abuse care or treatment is not included.

Orthotic Devices: Special devices such as splints, cervical collars, back braces or hip-knee-ankle or foot orthosis used to treat problems of the muscles, ligaments or bones of the skeletal system.

Ostomy Supplies: Includes, but isn't limited to, pouches, skin barriers, adhesives, belts and filters.

Out-of-pocket Maximum: A maximum amount of Coinsurance that you must pay for Covered Services during a Benefit Period. The Out-of-pocket Maximum is made up of the Coinsurance amounts payable by you. It doesn't include any Deductibles, Copayments and Coinsurance for certain services as indicated in the Schedule of Benefits.

Outpatient: A Member who receives services or supplies at a Hospital, Skilled Nursing Facility, Clinic or ambulatory surgical center that doesn't require an overnight stay.

Over-the-counter Drug: A drug that doesn't require a prescription.

Pharmacy: A provider that is licensed to dispense medications a doctor prescribes. It doesn't include a Physician's office or a Pharmacy affiliated with or a part of a Hospital, Skilled Nursing Facility or other type of similar institution.

Pharmacy Benefit Manager (PBM): A company that has a written contract with us to manage the Prescription Drug benefit program according to this Policy.

Physician: A person (other than an intern, resident or house Physician) duly licensed as a medical doctor, oral surgeon, osteopath, chiropractor, optometrist, ophthalmologist, dentist, podiatrist or licensed doctoral psychologist, legally entitled to practice, within the scope of his or her license and who normally bills for his or her services.

Policyholder: You, a parent or Legal Guardian who obtained this insurance Policy to cover you and/or your Dependents and who is the owner of the Policy and payer of the premiums. The Policyholder is responsible for assuring that all required Preauthorization and Approvals for services and supplies are obtained.

Pre-admission Testing: Tests and studies done on an Outpatient basis that are necessary in connection with and prior to a Member's surgical procedure. Pre-admission Testing doesn't include tests or studies performed to establish a diagnosis.

Preferred Blue Provider: A Provider who has agreed to accept our allowance as payment in full for Covered Services. Members will still be responsible for any Deductibles, Copayments, Coinsurance and non-covered procedures.

Prescription Drug: A drug that has been approved by the FDA and labeled "Caution: Federal Law Prohibits Dispensing Without Prescription," or labeled in a similar manner. Only a licensed registered pharmacist can dispense it according to a Physician's Prescription Order. Injectable insulin is also included.

Brand-name Drug: A Prescription Drug that is manufactured under a registered trade name or trademark. A Brand-name Drug may be a Preferred Drug or a Non-preferred Drug.

Generic Drug: A Prescription Drug that has the same active ingredient(s) as the Brand-name Drug but is not manufactured under a registered Brand-name or trademark.

Non-preferred Drug: A Prescription Drug that has not been chosen by us, or our designated Pharmacy Benefit Manager, to be a Preferred Drug. This includes any Brand-name Drug that has an "A" rated Generic Drug available.

Preferred Drug: A Prescription Drug that has been reviewed for cost, clinical effectiveness and quality. Preferred Drugs are Brand-name Drugs or Generic Drugs that are preferred by us, or our designated Pharmacy Benefit Manager, for dispensing to Members when appropriate. The Preferred Drug list is subject to periodic review and updates by us, or our designated Pharmacy Benefit Manager without notice.

Prescription Drug Coinsurance: The percentage of Allowable Charges for Prescription Drugs that the Member pays. The Prescription Drug Coinsurance, if applicable, will be shown in the Schedule of Benefits.

Prescription Drug Deductible: The amount, if any, shown in the Schedule of Benefits, of covered Prescription Drug charges each Member is responsible for paying each Benefit Period before Prescription Drug benefits are payable. This is a separate Deductible and will not apply to your Benefit Period Deductible or the Out-of-pocket Maximum (if this Policy has an Out-of-pocket Maximum).

Prescription Drug Maximum: The maximum amount, if shown in the Schedule of Benefits, that we'll pay for Prescription Drugs for each Member, each Benefit Period.

Primary Care Physician: A family doctor, general Physician, pediatrician, osteopath, emergency medicine Physician, OB/GYN or internal medicine Physician.

Prosthetic Devices: Artificial replacement body parts needed to ease or correct a condition caused by an illness, injury or birth defect, disease or anomaly. A Physician must order the appliance or device and we must determine it to be Medically Necessary.

Provider: A Facility, Hospital, Skilled Nursing Facility, Rehabilitation Facility, Psychiatric/Substance Abuse Facility, Physician, Psychologist, other mental health clinicians (when Preauthorized) and a Clinic licensed as required by the state where located, performing within the scope of the license, and acceptable to us or as listed:

1. Durable Medical Equipment Supplier
2. Independent Clinical Laboratory
3. Occupational Therapist
4. Pharmacy
5. Physical Therapist
6. Speech Therapist
7. Home Health Care Provider
8. Hospice Care Provider

Psychiatric Conditions: See Mental Health Services and/or Substance Abuse.

Psychiatric/Substance Abuse Facility: A Facility accredited by the Joint Commission on Accreditation of Health Care Organizations for the purpose of Mental Health Services and/or Substance Abuse care. This Facility may also be a ward, floor or other area contained within a Hospital whose primary purpose is treatment of Mental Health and Substance Abuse.

Rehabilitation Facility: A Hospital or other freestanding medical Facility that has a written agreement with us to provide on an Inpatient or Outpatient basis, a multidisciplinary therapeutic program that includes physical therapy, occupational therapy and other therapeutic interventions directed toward the restoration of full function and independent living for patients with neurological or other physical illnesses or injuries.

Rider: A supplement to the Policy that limits or excludes coverage. A Rider may be issued based on information contained in the application as well as other sources. A Rider may also be issued if we learn of medical or personal information, that for whatever reason, was not disclosed or revealed, or was misstated or incorrect in the application and not corrected or disclosed before the Policy was issued, and that information would have been material to us deciding to issue the Policy.

Skilled Nursing Facility: A licensed institution, other than a Hospital, that has a written agreement with us or another Blue Cross plan, which meets all six of these requirements:

1. Maintains permanent and full-time Facilities for bed care of resident patients; and
2. Has the services of a Physician available at all times; and
3. Has a registered nurse (RN) or Physician on full-time duty who's in charge of patient care along with one or more registered nurses (RNs) or licensed practical nurses (LPNs) on duty at all times; and
4. Keeps a daily medical record for each patient; and

5. Is primarily providing continuous skilled nursing care for sick or injured patients during the recovery stage of their illnesses or injuries and is not, other than incidentally, a rest home or a home for Custodial Care for the aged; and
6. Is operating lawfully as a nursing home in the area where it is located.

In no event, will the term "Skilled Nursing Facility" include an institution that mainly provides care and treatment for substance or alcohol abuse or Mental Health Services.

Sound Natural Tooth: Teeth that are free of active or chronic decay, have at least 50% bony support, are functional in the arch and have not been excessively weakened by multiple dental procedures. Also includes teeth that have been restored to normal function.

Specialist: A Physician who has received advanced training related to treatment of diseases or injury of particular parts of the body and who limits his or her practice to that area of medicine.

Specialty Drugs (including generic Specialty Drugs): FDA approved Prescription Drugs that treat a complex clinical condition and/or require special handling such as refrigeration. They normally require unusual/complex clinical monitoring and special training. Specialty Drugs include, but aren't limited to, infusible specialty drugs for acute and chronic diseases, injectable and self-injectable drugs for acute and chronic diseases, biotechnology medicines and specialty oral drugs or other dosage forms. A generic Specialty Drug has the same active ingredients as a brand name Specialty Drug but isn't manufactured under a registered brand name or trademark.

Specialty Drug Copayment: The amount payable (if any) by the Member for each Specialty Drug, as shown on the Schedule of Benefits. The Specialty Drug Copayment will not apply to the Prescription Drug Deductible (if any), the Specialty Drug Deductible (if any), the Deductible, the Specialty Drug Out-of-pocket Maximum (if any) or the Out-of-pocket Maximum (if any) shown in the Schedule of Benefits and will continue to apply even after you reach your Specialty Drug Out-of-pocket Maximum (if any) and/or the Policy Out-of-pocket Maximum (if any).

Specialty Drug Deductible: The amount (if any) shown in the Schedule of Benefits of all covered Specialty Drug charges each Member must pay each Benefit Period before Specialty Drug benefits are payable. The Specialty Drug Deductible will not apply to the Policy Deductible, the Specialty Drug Out-of-pocket Maximum, if any, or the Out-of-pocket Maximum, if any.

Specialty Drug Network Provider: A Provider that has a written agreement to participate in a special pharmaceutical network with the Corporation to provide Specialty Drugs. A Specialty Drug Network Provider also agrees to accept the Corporation's allowance as payment in full for Covered Expenses except for any Deductibles, Copayments and Coinsurance due from the Member. A Specialty Drug Network Provider may be different from a Preferred Blue Provider.

Specialty Drug Out-of-pocket Maximum: The maximum amount of Coinsurance, if shown in the Schedule of Benefits, you'll have to pay for covered Specialty Drugs during a Benefit Period. It doesn't include any Allowable Charges applied to the Out-of-pocket Maximum.

Substance Abuse: The use of drugs or alcohol where you require medical services that are defined, described or classified as psychiatric disorders or conditions in the latest publication of The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*. This doesn't include services for treatment of Mental Health Services.

Surgery: 1) the performance of generally accepted operative and cutting procedures including, endoscopic examinations and other invasive procedures; 2) the correction or treatment of fractures and dislocations; and 3) other procedures as reasonable and as approved by us. This includes the usual necessary and related pre- and post-operative care.

Trauma: Physical injury cause by accident, collision, fire wind or other sudden and/other catastrophic natural forces. Trauma does not mean or include injury or bodily function problems resulting from pregnancy, birth or multiple births, whether vaginally or by Cesarean section. Non-covered Physician services such as plastic Surgery or reconstructive Surgery or Cosmetic Surgery done simultaneously with covered surgical services are not payable.

Transplant Benefit Period: For an organ, the period begins on the admission date for the transplant surgery and continues for 12 months. For bone marrow, the period begins on the first date of mobilization therapy, marrow/stem cell harvest date or Inpatient admission date for the transplant procedure, whichever occurs first, and will continue for 12 months.

Transplant Lifetime Maximum: The maximum amount of benefits provided in a lifetime for each Member for each of the transplants listed on the Schedule of Benefits. Once the Transplant Lifetime Maximum has been met, no additional transplant benefits will be provided for that type of transplant.

Urgent Treatment Care: Care for an illness or injury that is serious or acute and requires immediate care, but is not life or limb threatening.

Urgent Treatment Facility: A medical facility, other than a Hospital emergency room, where ambulatory patients can be treated on a walk-in basis, without appointment, and receive immediate non-emergency care.

Waiting Period: The period that must pass before you are eligible to be covered for benefits under the terms of this Policy. The Waiting Period begins on the day you substantially filled out your application and ends on the first day of coverage.

C. PREAUTHORIZATION AND APPROVAL

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). MRIs, MRAs, CT Scans and PET Scans performed in an Outpatient Facility or a Physician's office require Preauthorization by National Imaging Associates.

Preauthorization means that a service is Medically Necessary for treatment of the patient's condition. **Preauthorization doesn't verify benefits or guarantee that we will pay benefits. Payment is subject to patient eligibility, Pre-existing Condition Limitations and all other limitations or exclusions of the Policy. We will make our final benefit determination when we process your claims.** If you have any questions about this, please contact the Claims Service Center.

The Claims Service Center cannot verify whether a particular benefit will be paid. Payment can only be determined once a claim is submitted.

Tell your Physician that your health insurance Policy requires advance Preauthorization. In-network Providers will be familiar with this requirement and will get the necessary approvals.

If you don't use an In-network Provider, it's your responsibility to contact us before receiving services and/or supplies. If you don't get preapproval, then we may not pay benefits or pay only reduced benefits.

If you are undergoing a human organ and/or tissue transplant, written Preauthorization from us must be obtained in advance. **If we don't preapprove these services in writing, then we won't pay any benefits.**

If your request for Preauthorization of services is denied, you can request further review under the guidelines set out in the *Grievance/Appeals Procedures* Section of this Policy. Remember that Preauthorization and Approval denials are considered denied claims for purposes of appeals and grievances.

Types of Approval

There are five different types of approval:

1. Preadmission Review
2. Emergency Admission Review
3. Continued Stay Review
4. Preauthorization Review
5. Preauthorization for Mental Health Services and/or Substance Abuse Care

Here are more details about each one:

Preadmission Review — Before you are admitted to a Hospital or Skilled Nursing Facility, Preadmission Review approval must be obtained. If you've just had a baby and your newborn is sick and must stay in the Hospital, approval must be obtained within 24 hours of your discharge.

If approval isn't obtained, or if we don't approve the admission and you are still admitted, we won't pay benefits for any part of the room and board charges. If a Preferred Blue Hospital or Skilled Nursing Facility doesn't get approval, it can't bill you for room and board charges. An Out-of-network Provider, however, can bill you for the penalty.

An admission for physical rehabilitation requires Preauthorization Review from us or we won't pay benefits.

Emergency Admission Review — If you experience an emergency illness or injury, go to the nearest emergency room right away or call 911 for help. We don't expect you to wait for approval before you go to the Hospital.

Medical Services must be notified within 24 hours of the emergency admission, or by 5:00 p.m. of the next working day following the admission. (Exceptions may be made for reasons beyond your control.)

If Emergency Admission Review approval isn't obtained within 24 hours or by the next working day, we won't pay benefits for any part of the room or board charges. If a Preferred Blue Hospital or Skilled Nursing Facility doesn't get approval, it can't bill you for room and board charges. An Out-of-network Provider, however, can bill you for the penalty.

Continued Stay Review — It's possible that you will need to remain in the Hospital or Skilled Nursing Facility for a period longer than we originally approved. In this case, Continued Stay Review Approval must be obtained from Medical Services.

If a Continued Stay Review approval isn't obtained, or if we don't approve the continued stay but you remain in the Hospital or Skilled Nursing Facility, we won't pay benefits for any part of the room and board charges for the period of the continued stay. If a Preferred Blue Hospital or Skilled Nursing Facility doesn't get approval, it can't bill you for room and board charges for the continued stay. An Out-of-network Provider, however, can bill you for the penalty.

Preauthorization Review — A number of services and medical procedures require Preauthorization Review. Please refer to your Schedule of Benefits for a list of the services or procedures and what penalty will apply if Preauthorization is not obtained.

If a Preferred Blue Provider doesn't get Preauthorization for you, it can't bill you for the denied or reduced benefits to do Preauthorization not being obtained, but an Out-of-network Provider can bill you the penalty.

Preauthorization for Mental Health Services and/or Substance Abuse Care – Companion Benefit Alternatives, Inc. (CBA) must preapprove any Inpatient or Outpatient treatment for Mental Health Services and/or Substance Abuse Care.

When approval isn't obtained for Inpatient Mental Health Services and/or Substance Abuse care, we'll deny covered charges for room and board. If a Preferred Blue Hospital doesn't get approval for you, it can't bill you for room and board charges. When approval isn't obtained for Outpatient Mental Health Services and/or Substance Abuse Care, we will reduce benefits as shown on the Schedule of Benefits. If an In-network Provider doesn't get approval for you, it can't bill you for the reduction. An Out-of-network Provider, however, can bill you for the reduction.

Don't call the Claims Service Center for Preauthorization and Approval. A Claims Service Representative cannot give approval. Please refer to the *How to Contact Us* provision of this Policy for the telephone numbers to call for approval. You can also find these numbers on the front of your ID card.

If you call for Preauthorization and Approval, you'll talk with a medical professional. He or she will ask you for this information:

- Your name and ID number
- The patient's name and relationship to you
- The Physician's or Provider's name, address and phone number
- The Hospital or Skilled Nursing Facility's name, address and phone number
- The reason the patient needs care or treatment

After careful review, we will let your Physician and Hospital know if we approved the admission or service as Medically Necessary and how long the approval is valid. Preauthorization and Approval does not verify you are eligible for the services under your Policy or that we will pay for the services. Payment can only be determined when your claim is submitted.

D. COVERED SERVICES

We will pay benefits for Covered Services according to the provisions described in this Policy. We base benefit payments on a percentage of Allowable Charges. Benefits are subject to Deductibles, Copayments, Benefit Period Maximums, Lifetime Maximums, benefit limitations and exclusions as shown on the Schedule of Benefits and described in this Policy. Preauthorization and Approval must be obtained on certain services to receive maximum benefit payments. See the *Preauthorization and Approval* section for details.

Covered Services include only the services and supplies described below to the extent the charges are not limited or excluded in any provisions of this Policy. The services and supplies must:

1. Be prescribed by or performed by or upon the direction of a Physician; and
2. Be done for diagnosis or treatment of a Member's illness or injury, except as specifically noted herein; and
3. Be approved as Medically Necessary and appropriate; and
4. Not be Investigational or Experimental in nature. Investigational and Experimental includes but is not limited to the following:
 - Uses of allogeneic bone marrow transplantation (between two related or unrelated people) or syngeneic bone marrow transplantation (from one identical twin to the other) along with other forms of stem cell transplant (with or without high doses of chemotherapy or radiation) in cases in which less than four of the six complex antigens match; cases in which mixed leukocyte culture is reactive; and AIDS and HIV infection;
 - Adrenal tissue to brain transplants;
 - Islet cell transplants;
 - Procedures that involve the transplantation of fetal tissues into a living recipient; and
5. Not be for luxury or convenience; and
6. Be provided after the Effective Date and before the termination of coverage, unless otherwise specified.

Covered Services don't include treatment for complications resulting from any non-covered procedure or condition, acupuncture or travel expenses.

The following are Covered Services:

Ambulance Service – Ambulance service providing local transportation by means of a vehicle used only for transporting the sick and injured from a Member's home or the scene of an accident or medical emergency to a Hospital or between Hospitals when such Hospital is the closest Facility that can provide Covered Services appropriate to the Member's condition. If there is no Hospital in the local area that can provide Covered Services appropriate to the Member's condition, the ambulance service provides transportation to the closest Hospital outside the local area that can provide the necessary service.

Benefits will also be provided for ambulance service providing local transportation by means of a vehicle used only for transporting the sick and injured from a Hospital to the Member's home.

Cleft Lip and Palate – The Medically Necessary care and treatment of a cleft lip and palate and any condition or illness that is related to or caused by a cleft lip and palate. Cleft lip and palate means a congenital cleft in the lip or palate or both. Care and treatment will include, but are not limited to, these types of Medically Necessary care:

1. Oral and facial Surgery, surgical management and follow-up care;
2. Prosthetic treatment such as obturators, speech appliances and feeding appliances;
3. Orthodontic treatment and management;
4. Treatment and management for missing teeth (prosthodontics);
5. Ear, nose and throat (otolaryngology) treatment and management;
6. Hearing (audiological) assessment, treatment and management including surgically implanted hearing aids; and
7. Physical therapy assessment and treatment.

If a Member with a cleft lip and palate is also covered by a dental policy, then teeth capping, prosthodontics and orthodontics will be covered by the dental policy to the limit of coverage provided and any excess after that will be provided by this Policy.

Complications of Conditions due to Pregnancy – A condition needing medical treatment during or after a pregnancy. The condition must be diagnosed as separate or distinct from the pregnancy or caused by it. Examples are:

- Kidney disease or inflammation of kidneys (acute nephritis);
- Heart failure (cardiac decompensation);
- Disease of the blood vessels (vascular), blood cells (hemopoietic), nervous or hormone (endocrine) systems.

Also includes:

- Non-elective Cesarean section;
- Miscarriage;
- Termination of ectopic or tubal pregnancy;
- Excessive vomiting during pregnancy (hyperemesis gravidarum); and
- Hypertension or toxemia (pre-eclampsia).

Dental Services to Sound Natural Teeth Related to Accidental Injury – Only when such care is for treatment, Surgery or appliances caused by accidental bodily injury (except dental injuries occurring during the natural act of chewing). Benefits are limited to care completed within one year of such accident and while the patient is still covered under this Policy. Benefits are also limited to the Benefit Period Maximum Payment shown on the Schedule of Benefits.

Diabetes – Equipment, supplies, Outpatient self-management training and education for the treatment of Members with diabetes if it's Medically Necessary and a health care professional prescribes it. This health care professional must be legally authorized to prescribe such items and follow minimal standards of care for diabetes. These minimal standards of care are adopted and published by the Diabetes Initiative of South Carolina.

Diabetes self-management training and education will be provided on an Outpatient basis when done by a registered or licensed health care professional certified in diabetes education.

Diagnostic Services – Medically Necessary procedures ordered by a Physician because of specific symptoms to identify the nature and/or extent of a condition or disease. Diagnostic services do not include any procedure related to sexual dysfunction or fertility. Benefits will be provided on an Inpatient and Outpatient basis. We will reduce benefits for Inpatient diagnostic services to Outpatient services when services could have been safely done on an Outpatient basis. Diagnostic services include, but are not limited to:

1. Radiology, ultrasound and nuclear medicine;
2. Laboratory and pathology;
3. ECG, EEG and other electronic diagnostic medical procedures and physiological medical testing;
4. Surgical pathology — pathological examination of tissue removed surgically, by resection or biopsy, on an Outpatient basis. This doesn't include smear techniques;
5. Magnetic Resonance Imaging (MRI); and
6. Gastrointestinal Endoscopies.

Durable Medical Equipment – If a Physician prescribes Durable Medical Equipment and it's Medically Necessary for the treatment of the patient's condition, then we'll provide benefits for the purchase price or the rental cost up to the purchase price for Durable Medical Equipment as shown in your Schedule of Benefits. We provide benefits for standard Durable Medical Equipment only. We'll provide benefits for deluxe/specialized equipment at the standard equipment allowance. The rental benefits cannot exceed the purchase price of the equipment. Preauthorization and Approval is required when the purchase price or rental cost is \$500 or more. Benefits are limited to the Benefit Period Maximum Payment shown on the Schedule of Benefits.

Benefits are not available for a penile prosthesis that is necessary due to any medical condition or organic disease. A penile prosthesis will be considered for payment only after Medically Necessary prostate Surgery. Benefits are also not available for oral appliances used to treat snoring.

Home Health Care Services – Please refer to your Schedule of Benefits to see what benefit limitations apply. Home Health Care includes:

1. Services by a registered nurse (RN) or licensed practical nurse (LPN);
2. Services provided by a home health aide or medical social worker;
3. Nutritional guidance;
4. Diagnostic services;
5. Administration of Prescription Drugs;
6. Medical and surgical supplies;
7. Oxygen and its use; and
8. Durable Medical Equipment (A separate Preauthorization Review isn't needed when we approve the entire Home Health Care plan).

Physical, respiratory, speech and occupational therapy are also covered as part of an approved Home Health Care plan. However, the Short-term Physical Therapy Maximum Payment as shown in the Schedule of Benefits applies to these services.

Hospice Care – Please refer to your Schedule of Benefits to see what benefit limitations apply. Hospice Care includes:

1. Services provided by a registered nurse (RN) or licensed practical nurse (LPN);
2. Services provided by a home health aide or medical social worker;
3. Nutritional guidance;
4. Diagnostic services;
5. Administration of Prescription Drugs;
6. Medical and surgical supplies;
7. Oxygen and its use;
8. Durable Medical Equipment (A separate Preauthorization Review isn't needed when we approved the entire Hospice Care plan);
9. Respite care; and
10. Family counseling concerning the patient's terminal condition.

Physical, respiratory, speech and occupational therapy are also covered as part of an approved Hospice Care plan. However, the Short-term Therapy Maximum Payment as shown in the Schedule of Benefits applies to these services.

Hospital Services – Benefits don't include routine nursery charges.

1. Inpatient Hospital Services – Include:
 - a. A semi-private room and special care unit – When a Member is admitted to a Hospital in which all rooms are private, the most prevalent semi-private room rate, as determined by us, will be considered the private room allowance;
 - b. Bed and board – including meals, special diets and general nursing services;
 - c. Ancillary services, such as:
 1. Use of operating, delivery and treatment rooms;
 2. Prescribed drugs;
 3. Administration of blood and blood processing;
 4. Anesthesia, anesthesia supplies and services provided by an employee of the Hospital;
 5. Medical and surgical dressings, supplies, casts and splints;
 6. Diagnostic services;
 7. Therapy services; and
 8. Rental of Hospital equipment up to the purchase price during the Inpatient stay.

The day that a Member leaves a Hospital, with or without permission, is treated as the day of discharge and won't be counted as an Inpatient care day, unless he or she returns to the Hospital by midnight of the same day. The day the Member returns to the Hospital is treated as the day of admission and is counted as an Inpatient care day. The days during which a Member is not physically present for Inpatient care are not counted as Inpatient days.

2. Outpatient Hospital Services – Include:
 - a. Emergency Medical Care
 - b. Surgery
 - c. Other services not specified above and not specifically excluded.

Human Organ and/or Tissue Transplant – In order for Benefits to be provided for covered transplant procedures, Preauthorization must be obtained. If written Preauthorization isn't obtained, we won't pay benefits for any transplant procedure.

Benefits for covered transplants are subject to Deductibles, Copayments, the Transplant Lifetime Maximums and a Transplant Benefit Period. Transplant Lifetime Maximums are shown on the Schedule of Benefits. All benefits provided during a Transplant Benefit Period will apply toward the Transplant Lifetime Maximum. Covered Prescription Drugs don't apply toward the Transplant Lifetime Maximum.

Organ transplant coverage includes all expenses for medical and surgical services and supplies you receive for human organ and/or tissue transplants while you are covered under this Policy. This includes donor organ procurement. Organ transplants do not include transplants involving mechanical or animal organs.

1. Benefits are provided for living donor, human organ transplants, subject to the following conditions:
 - a. When both the transplant recipient and the donor are Members, benefits will be provided for both.
 - b. When the transplant recipient is a Member and the donor is not, benefits will be provided for both the recipient and, to the extent benefits remain and are available under this Policy, for the donor after the recipient's own expenses have been provided. Benefits provided to the donor will be charged against the recipient's coverage under this Policy.
 - c. When the transplant recipient is not a Member and the donor is, no benefits will be provided to either the donor or the recipient.
2. Limited benefits are provided for the specified major human organ transplant procedures listed below. These benefits are subject to all other provisions of the Policy.
 - a. Single/double kidney, pancreas and kidney, heart, single/double lung, liver, pancreas, heart and single/double lung and bone marrow transplants.
3. Benefits may be available when a malignancy is present for high dose chemotherapy followed by hematopoietic stem support, either autologous (the patient is the donor) bone marrow transplant, peripheral stem cell or allogeneic bone marrow transplant when the procedure is considered Medically Necessary.
4. Benefits may be available for allogeneic bone marrow transplantation in the treatment of developmental and non-malignant diseases of bone marrow when the procedure is considered Medically Necessary.

Benefits for allogeneic or syngeneic bone marrow transplants as described in items 3 and 4 above are available only if there are at least four out of six histocompatibility complex antigen matches between the patient and the donor and the mixed lymphocyte culture is nonreactive.

5. The following expenses related to transplants of tissue (rather than whole major organs), except fetal tissue, are covered, subject to all the provisions of this Policy:
 - a. Blood transfusions (but not whole blood and blood plasma);
 - b. Autologous parathyroid transplants;
 - c. Corneal transplants;
 - d. Bone and cartilage grafting; or
 - e. Skin grafting.

Mastectomy – Hospitalization will be provided for at least 48 hours following a mastectomy. If you're released early, then we'll provide benefits for at least one home care visit if the attending Physician orders it.

We'll also provide benefits for prosthetic devices, reconstruction of the breast on which the mastectomy was performed and physical complications for all stages of mastectomy including lymphedemas. This includes Surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance as determined in consultation with the attending Physician and the patient.

Medical Supplies – Benefits are payable as shown on the Schedule of Benefits for Medically Necessary supplies.

Mental Health Services and/or Substance Abuse Care – We'll provide benefits as shown in the Schedule of Benefits for Mental Health Services and/or Substance Abuse care when a Member is a patient in a Hospital or Psychiatric/Substance Abuse Facility or is receiving Outpatient services. Mental Health Services and/or Substance Abuse care don't include long-term, residential care or conditions related to attention deficit disorder, learning disabilities, behavioral problems; marriage, family or child counseling for the treatment of premarital, family or child relationship dysfunctions or Inpatient confinement for environmental changes.

The Benefit Period Maximum and the Lifetime Maximum for Inpatient, Outpatient, Physician and Prescription Drug treatment, In-network and Out-of-Network for Mental Health Services and/or Substance Abuse care is combined and is shown on the Schedule of Benefits.

Amounts a Member pays for the Mental Health Services and/or Substance Abuse care won't apply toward the Out-of-pocket Maximum and the payment for these services don't increase when the Out-of-pocket Maximum is met.

All Mental Health Services and/or Substance Abuse Care must be preauthorized. If Mental Health Services and/or Substance Abuse Care are not preauthorized, the benefits will be reduced as shown in the Schedule of Benefits.

Orthotic Devices – Benefits are payable as shown on the Schedule of Benefits for Medically Necessary Orthotic Devices.

Ostomy Supplies – Benefits are payable as shown on the Schedule of Benefits for Medically Necessary Ostomy Supplies.

Out-of-country – We will provide Out-of-country benefits based on the In-network Provider allowance or the total charge, whichever is less. Out-of-country benefits consist of all services provided or supplies received outside the United States.

Physician Services – Benefits don't include: treatment of excessive sweating; sterilization, the reversal of sterilization, infertility or impotency treatment, treatment of sexual dysfunction, or for the enhancement of sexual performance; transsexual procedures; reduction mammoplasty for macromastia unless the Member is within 20% of the ideal body weight; charges for medicine, drugs, appliances, supplies, blood and blood products; refractive care, such as radial keratotomy, laser eye Surgery or LASIK, lamellar keratoplasty or any such procedures that are designed to alter the refractive properties of the cornea; and dorsal rhizotomy in the treatment of spasticity. Benefits also don't include the treatment of obesity or for the purpose of weight reduction or control (even in cases of morbid obesity) including, but not limited to, gastric bypass or gastric banding, intestinal bypass, liposuction, wiring mouth shut and any related procedures as well as any complications from or the reversal of such restrictive and diversionary procedures. Reconstructive procedures made necessary by weight loss and any Hospital services associated with any of the above services or procedures; or Cosmetic Surgery are also not included in these benefits. Benefits are payable for the following:

1. Surgical Services

- a. Reconstructive Surgery – to restore bodily function or correct deformity resulting from disease, trauma, congenital anomalies or developmental anomalies. For the purposes of this Policy, Reconstructive Surgery does not include Cosmetic, plastic or other types of surgical services or Physician Services state above that are not covered as stated above.
- b. Multiple Surgical Procedures – When multiple surgical procedures are performed through the same incision or body opening during one operation, benefits are provided only for the primary procedure unless more than one body system is involved or the procedures are required for management of multiple trauma.

If two or more surgical procedures are performed through different incisions or body openings during one operation, benefits are provided for the additional procedures at 50% of the Allowable Charge for each procedure for up to four procedures. No additional benefits are payable for more than four procedures performed during one operation.

When more than one skin lesion is removed at one time, the Allowable Charge is covered for the largest lesion, 50% of the Allowable Charge is covered for the removal of the second largest lesion and 25% of the Allowable Charge is covered for removing any other lesions.

We designate certain surgical procedures that are normally exploratory in nature, as "Independent Procedures." The Allowable Charge is covered when such a procedure is performed as a separate and single entity. However, when an Independent Procedure is performed as an integral part of another surgical service, only the Allowable Charge for the major procedure will be covered.

- c. Anesthesia – Anesthesia ordered by the attending Physician and administered by a Physician other than the surgeon or assistant at Surgery.
- ## 2. Inpatient Services – Medical Care (except for routine nursery charges and the first medical exam of a newborn well baby) provided by a Physician to a Member, as a patient in a Hospital for a condition not related to Surgery or pregnancy, except as specifically provided herein. We won't pay benefits for Inpatient tests or treatment that could have been safely done on an Outpatient basis.
- a. Inpatient Medical Care Visits – Visits are limited to one per day. Inpatient medical services also include diagnostic services and therapy services done concurrently with medical care.
 - b. Intensive Medical Care – If a Member's condition requires intensive medical care, benefits are payable for one intensive medical care visit a day by the attending Physician.
 - c. Consultation – A consultation from another Physician may be ordered by a patient's attending Physician. For each consulting Physician, benefits are payable for one consultation during a single admission to a Hospital or Skilled Nursing Facility.

We won't pay benefits for daily medical visits by more than one Physician unless the Member has a separate medical condition the attending Physician can't treat. In this type of situation, benefits may be payable for one daily visit by each Physician.

Daily care by the surgeon, as well as pre- and post-operative care, is included in the benefits for Surgery. Unless the Member has a medical condition a surgeon can't treat, we won't provide benefits for medical care visits if the Member is hospitalized for Surgery.

- ## 3. Outpatient Medical Services – Medical Care provided by a Physician to a Member in an Outpatient setting for a condition not related to Surgery or pregnancy, except as specifically provided. Outpatient medical services don't include charges for telephone consultations, failure to keep a scheduled appointment, completion of claim forms or for furnishing medical records.
- a. Emergency Medical Care – The treatment of an Emergency Medical Condition.
 - b. Non-Routine Office Visits – Medical care visits and consultation for the examination, diagnosis and treatment of an injury or illness. Eligible Physician charges don't include "virtual office visits." A "virtual office visit" occurs when the Physician, treating, consulting, diagnosing, writing or approving a prescription, has never physically seen or physically examined the Member.
 - c. Home and Other Outpatient Visits – Medical care visits and consultations for the examination, diagnosis and treatment of an injury or illness.

Prescription Drugs – We'll provide benefits for Prescription Drugs as specified in the Schedule of Benefits.

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 in the current *Physician's Desk Reference* or as recommended under the guidelines of our Pharmacy Benefit Manager, whichever is lower.

We treat insulin as a Prescription Drug whether it's injectable or otherwise. Prescription Drugs don't include devices of any type, except contraceptive devices when shown on the Schedule of Benefits; artificial appliances; vitamins; infertility drugs; drugs for treatment of sexual dysfunction; Medical Supplies (Medical Supplies are paid under the regular Policy benefits); food supplements; Prescription Drugs for which there is an Over-the-counter Drug equivalent, Prescription Drugs used for or related to weight control, obesity, cosmetic purposes (such as Tretinoin or Retin-A), hair growth, hair removal, smoking cessation and Over-the-counter Drugs, devices, supplies or supplements.

Prescription Drugs must be dispensed in a licensed Pharmacy. Eligible Prescription Drugs don't include drugs obtained from a "virtual office visit." A "virtual office visit" occurs when the Physician treating, consulting, diagnosing, writing or approving a prescription has never physically seen or physically examined the Member.

The Pharmacy Benefit Manager (PBM) for us and some of our subsidiaries, contracts with and manages the Pharmacy network, negotiates prices with the Contracting Pharmacies and performs other administrative services. We receive financial credits directly from drug manufacturers and through our Pharmacy Benefit Manger (PBM). These credits are used to help stabilize overall rates and to offset costs. Reimbursements to Pharmacies or discounted prices charged at Pharmacies, are not affected by these credits.

Any Coinsurance percentage that you must pay for Prescription Drugs is based on the Allowable Charge at the Pharmacy and doesn't change when we receive any financial credit. Copayments are flat amounts and likewise don't change when we receive drug manufacturer or PBM credits.

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. If you don't obtain the required Preauthorization, no benefits will be provided.

You may be required to try certain drugs to treat your medical condition before we'll cover another drug for that condition.

Specialty Drugs are covered only if shown in the Schedule of Benefits.

Benefits won't be provided or paid for the following:

1. Service charges or handling fees for a Prescription Drug;
2. More than the number of days supply shown on the Schedule of Benefits;
3. Prescription refills in excess of the number specified on the prescription or refills dispensed more than one year after the original prescription date;
4. Prescription Drugs for Pre-existing Conditions or Ridered conditions; or
5. Prescription Drugs that are not Medically Necessary.

You must pay the Pharmacy at the time your prescription is filled.

When you buy drugs from a Contracting Pharmacy you must show the pharmacist your Blue Cross ID card. The pharmacist will know not to charge you more than the Allowable Charge for the drugs.

This Policy may not provide benefits at a non-Contracting Pharmacy. If benefits are available at a non-Contracting Pharmacy, it will be shown in the Schedule of Benefits. If benefits are available, Non-Contracting Pharmacies can charge you more than the Allowable Charge. Benefits for drugs purchased from non-Contracting Pharmacies will be paid at a lower percentage.

If you purchased the Drug Card, you (or your covered Dependent) must pay the Contracting Pharmacy:

1. The Prescription Drug Deductible, if applicable; and
2. The Prescription Drug Copayment or the Contracting Pharmacy's usual, reasonable and customary charge that would be charged to a non-Member, whichever is less; and
3. Any type of service charge including the administration or injection of a Prescription Drug; or
4. 100% of the cost of a Prescription order when a Member fails to show their identification card.

If a Contracting Pharmacy is not used, you (or your covered Dependent) must:

1. Pay the Pharmacy in full for the Prescription Order; and
2. File a claim form with us for reimbursement. The claim form must be obtained from us.

Preventive Benefits

1. Mammograms – Benefits will be provided, as shown on the Schedule of Benefits, according to the most recently published American Cancer Society (ACS) guidelines. A Contracting Mammography Provider must provide the services. These Providers are listed separately from the regular Preferred Blue Providers in the directory.
2. Pap Smears – Benefits will be provided, as shown on the Schedule of Benefits. An In-network Provider must provide the services.
3. PSA Testing – Benefits will be provided, as shown on the Schedule of Benefits, according to the most recently published guidelines of the American Cancer Society (ACS). An In-network Provider must provide the services.
4. Colorectal Cancer Screening/Testing – Benefits will be provided, as shown on the Schedule of Benefits, according to the most recently published American Cancer (ACS) guidelines.
5. Preventive Office Visits – Benefits will be provided, as shown on the Schedule of Benefits. Immunizations are not included.

Rehabilitation – Benefits for taking part in a multi-disciplinary team-structured rehabilitation program following severe neurological or physical disability are available. The Benefit Period Maximum and the Lifetime Maximum are shown on the Schedule of Benefits.

For these benefits to be available, you must meet these requirements:

1. A Physician must order all such care; and
2. Preauthorization and Approval in writing must be obtained; and
3. The documentation that goes with a request for a Preadmission/Preauthorization Review must have a detailed patient evaluation from a Physician. This evaluation must document to a reasonable degree of medical certainty that the patient has rehabilitation potential, and there is belief that this patient will be able to provide self-care and carry out his or her activities of daily living.

In order for benefits to continue, all care is subject to periodic review. This review will require documentation that the patient is making substantial progress toward set goals and that there continues to be significant potential for the patient to achieve these rehabilitation goals.

Skilled Nursing Facility Services – Services in a Skilled Nursing Facility. These services must 1) follow the onset of an injury or illness that occurred after the Effective Date, and 2) begin within 14 days after being discharged from a Hospital following an authorized hospitalization. The Benefit Period Maximum is shown on the Schedule of Benefits.

Specialty Drugs (including generic Specialty Drugs) – Please refer to your Schedule of Benefits to see if benefits for Specialty Drugs are included in your coverage. A Physician must prescribe Specialty Drugs. The prescription must be filled by a Specialty Drug Network Provider. Benefits for covered Specialty Drugs dispensed to you shall not exceed the quantity and benefit maximum, if any, as shown in your Schedule of Benefits. 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. Preauthorization is required for benefits to be available.

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.

The Pharmacy Benefit Manager (PBM) for us and some of our subsidiaries, contracts with and manages the Specialty Drug Network Provider network, negotiates prices with the Specialty Drug Network Providers and performs other administrative services. We receive financial credits directly from drug manufacturers through our PBM. The credits are used to help stabilize overall rates and to offset expenses. Reimbursements to Specialty Drug Network Providers, or discounted prices charged at Specialty Drug Network Providers, are not affected by these credits.

Any Coinsurance percentage that you must pay for Specialty Drugs is based on the Allowable Charge at the Specialty Drug Network Provider. It doesn't change when we receive any financial credit. Copayments are flat amounts and likewise don't change when we receive drug manufacturer or PBM credits.

Benefits won't be provided or paid for the following:

1. Service charges or handling fees for a Specialty Drug;
2. More than the number of days supply shown on the Schedule of Benefits;
3. Prescription refills in excess of the number specified on the prescription or refills dispensed more than one year after the original prescription date;
4. Specialty Drugs for Pre-existing Conditions or Ridered conditions; or
5. Specialty Drugs that are not Medically Necessary.

Therapy Services – Therapy services do not include any of the following unless specifically included in your Schedule of Benefits: medical social services, occupational, visual or speech therapy; recreational, educational or play therapy; biofeedback or psychological testing to determine if a learning disability or behavior disorder exists; therapy for learning disabilities and communication delay; perceptual disorders; behavioral disorders; mental retardation or vocational rehabilitation.

1. Short-term Physical Therapy Services – Services must be Medically Necessary, ordered by a Physician, performed by a licensed therapist and provided to promote the recovery of the Member from an illness, disease or injury. Physical Therapy is the treatment by physical means and devices to relieve pain, restore maximum function and prevent disability following disease, injury or loss of body part

The Maximum Payment per Member per Benefit Period for Short-term Therapy Services is shown on the Schedule of Benefits. Benefits are available for the following therapies:

2. Other Therapy Services
 - a. Chemotherapy – The treatment of malignant disease by chemical or biological antineoplastic agents that have received full, unrestricted market approval from the FDA.
 - b. Dialysis Treatment – The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or retinol dialysis. Dialysis treatment includes home dialysis.
 - c. Radiation Therapy – The treatment of disease by X-ray, radium or radioactive isotopes.

Temporomandibular Joint Disorder (TMJ) – Benefits will provided for Medically Necessary surgical correction of disorders of TMJ. 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 doesn't establish Medical Necessity. Preauthorization is required. Benefits do not include office visits, splints, braces, guards, etc.

D.1 OPTIONAL COVERED SERVICES

The following optional Covered Services are available for an additional premium. The Schedule of Benefits will show if you purchased these options.

Accident Medical Expense – Benefits will be provided, if purchased, as shown in the Schedule of Benefits for Covered Services incurred by you (or your covered Family Member) due to an Accidental Injury will be payable if: 1) the injury results directly from Accidental Injury, independently of disease, bodily infirmity (frailty or condition causing weakness) or any other cause, and 2) the Accidental Injury is sustained and the Allowable Charges for Covered Expenses are incurred while this Endorsement is in force. No benefits will be provided for injuries for which benefits are provided under Workers' Compensation, employer's liability or similar laws, motor vehicle no fault plans, unless prohibited by law, or injuries occurring while the Member is engaged in any activity pertaining to any trade, business, employment or occupation for wage or profit.

Benefits paid under this optional benefit may not be used to satisfy the Deductible.

Allowable Charges for Covered Services in excess of the amount specified in the Schedule of Benefits will be subject to the Deductible and Coinsurance.

Benefits for accidental injury are limited as shown in the Schedule of Benefits.

Maternity – Benefits will be provided, if purchased, as shown in the Schedule of Benefits. Optional maternity benefits are not available to covered Dependent Children.

Covered Services include only:

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.

Prescription pre-natal vitamins are only covered if the maternity option has been purchased.

Benefits will be provided due to a Pregnancy as shown in the Maternity Schedule. Pregnancy benefits, as provided in this optional benefit, are subject to the Policy's Pre-existing Condition Limitation. In the event we cancel, or refuse to renew this Policy and you purchased this optional maternity benefit, this Policy will provide for an Extension of Benefits as to pregnancy commencing while the Policy is in force and for which benefits would have been payable had the Policy remained in force. For additional information, see Extension of Benefits.

You must contact Our Medical Management Staff within 12 weeks of medical confirmation by a Physician of the Pregnancy. In addition, you must call within the first 24 hours of an admission for delivery or as soon as reasonably possible. Any other admissions during a Pregnancy must be authorized in accordance with the Pre-Authorization and Approval procedures described in this Policy.

Policy benefits for the hospitalization and attendant professional services of the mother and the newborn child will be provided for at least 48 hours after a vaginal delivery, not including the day of delivery, and at least 96 hours following a cesarean section, not including the day of surgery, or to the date of discharge, whichever occurs first.

As used in this benefit, "Pregnancy" means the period of time from conception to delivery. The Pregnancy will be considered terminated on the date of the resulting childbirth, miscarriage or abortion.

Maternity benefits do not include the following:

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, sterilization or reversal of sterilization.
3. Complications of Pregnancy, as defined, are covered under the regular policy benefits and not under this optional benefit. Charges incurred due to Complications of Pregnancy will be subject to the Deductible, Coinsurance and all other Policy provisions.

Dental/Vision – We'll provide benefits for dental and vision services as shown in the Schedule of Benefits, if purchased.

E. THE BLUECARD® PROGRAM

The BlueCard Program is a 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. Blue Cross and Blue Shield of South Carolina is your Home plan, the entity with which you have the policy. The Blue Cross and Blue Shield Plan where you are 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.

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, the 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 get 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. The amount you pay, however, 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.

G. PRE-EXISTING CONDITION LIMITATION

If this Policy is issued with a Rider which excludes or limits coverage for a specific person and/or condition, that person and/or condition will not be covered unless the Member requests removal of the rider and we agree in writing to the removal of the rider.

Treatment, care, services, supplies or Prescription Drugs for Pre-existing Conditions are not covered until the Member has been insured under this Policy for 12 months. Coverage under any prior Health Insurance plan does not reduce the 12-month Pre-existing Condition Limitation under this Policy.

A Pre-existing Condition is a condition that is misrepresented or not revealed in the application and; a) for which symptoms existed before the Effective Date of coverage under this Policy that would cause a reasonable person to seek diagnosis, care or treatment; or b) for which medical advice or treatment was recommended by or received from a Physician.

A diagnosis is not required for a condition to be a Pre-existing Condition.

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

Listing the names of your Providers in the application does not mean you have provided your medical history. If you do not provide your complete and correct medical history and personal information in the application and any updates and/or changes to your medical or personal information up to the Effective Date of this Policy, we may rescind the Policy or issue a Rider to limit or exclude coverage had we known the true and correct facts at the time the Policy was issued, subject to the Time Limit on Certain Defenses provision.

H. EXCLUSIONS AND LIMITATIONS

Except as specifically provided in this 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 for 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 or settlement of a Workers' Compensation claim.
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 Member's immediate family; and for services for which a charge is normally not made in the absence of insurance.
5. Cosmetic Surgery except that Cosmetic Surgery doesn't include reconstructive Surgery incidental to or following Surgery resulting from trauma, infection or other diseases of the involved part, 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 doesn't include corrective Surgery or treatment for metabolic or peripheral vascular disease.
11. Dental care or treatment, except as shown in the Schedule of Benefits. However, removal of impacted teeth are never covered.
12. Eyeglasses, except as shown in the Schedule of Benefits; contact lenses (except after cataract Surgery) and hearing aids and examination for their prescribing or fitting.
13. Normal pregnancy or childbirth, except as provided when the Optional Maternity coverage is purchased. Your Schedule of Benefits will show if you have purchased the Optional Maternity coverage.
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.

I. GRIEVANCE/APEALS PROCEDURES

Please direct any complaints or disagreements you have regarding claims for services or benefits to us at (803) 264-3475 from Columbia, or 1-800-868-2500, extension 43475 from anywhere else. You may also send us a secure e-mail through the Ask Customer Service feature of My Insurance Manager on our Web site at www.SouthCarolinaBlues.com.

A Preauthorization and Approval denial will be considered a denied claim for purposes of this provision. You may direct any complaints or disagreements you have regarding a Preauthorization and Approval to us at (803) 736-5990 from Columbia, or 1-800-327-3238 from anywhere else.

Grievances

If you choose to file a formal grievance, submit it in writing to us at the Claims Service Center, Post Office Box 100300, Columbia, South Carolina 29202. The grievance should include your name, address, Policy number, Social Security Number and any other information, documentation or evidence to support your request. You must submit your formal grievance within 90 days of the event that resulted in your complaint.

We will acknowledge a formal grievance within 10 working days of its receipt. We will send you our decision in writing within 30 days after we receive your formal grievance. If there are extraordinary circumstances requiring a more extensive review, we may take up to 90 days to review your case before making a decision.

Appeals

If you are still not satisfied with our decision, you may request an appeal. You have 30 days after you receive our decision on the formal grievance to request an appeal. Send your request for an appeal to the Claims Service Center, Post Office Box 100300, Columbia, South Carolina 29202.

External Reviews

After your internal appeals are completed, you will be notified in writing of your right to request an external review. You should file a request for external review within 60 days of receiving that notice. You will be required to authorize the release of any medical records that may be needed for the external review. If you need assistance during the external review process, you may contact the South Carolina Department of Insurance at the following address and telephone number:

South Carolina Department of Insurance
Post Office Box 100105
Columbia, SC 29202-3105
1-800-768-3467

Standard External Reviews

You may request an external review if we deny your claim, either in whole or in part. The claim in question must be greater than \$500 and you may be held financially responsible for the covered benefits. You may only request an external review after you have completed the grievance and appeal process above. You may request an external review without completing the grievance and appeal process above if:

1. Your Physician has certified in writing that you have a serious medical condition; or
2. The denial of coverage was due to the service being Investigational or Experimental and your Physician certifies:
 - a. Your condition is a serious disability or you have a life-threatening disease; and
 - i. standard health care services or treatments have not been effective in improving your condition; or
 - ii. standard health care services or treatments are not medically appropriate; or
 - iii. the recommended or requested service or treatment is more beneficial than the standard health care service or treatment covered by us; and
 - b. Medical and scientific evidence shows that treatment that was denied is more beneficial to you than available standard health service 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.

Within 5 business days of your request for an external review, we will respond by either assigning your review to an independent review organization (IRO) and forwarding your records to it or telling you in writing that your situation doesn't meet the requirements for an external review and explaining the reasons. Where your request is for an expedited review, we will respond by either assigning your review to an IRO and forwarding your records to it by overnight delivery or telling you in writing that your situation doesn't meet the requirements for an external review and explaining the reasons as quickly as possible.

If your request is assigned to an IRO, the IRO will determine within 5 business days after receiving your request whether all the information, certifications and forms required to process an external review have been provided. If the IRO needs additional information, you will be allowed to submit additional information in writing to them within 7 business days.

If your request is not accepted for external review, the IRO will inform you and us in writing of the reason(s) your request was not accepted.

The IRO will provide written notice of its decision within 45 days after it receives the request, including:

1. A general description of the reason for the request for external review;
2. The date the independent review organization received the request from us;
3. The date the external review was conducted;
4. The date of its decision;
5. The principal reason or reasons for its decision;
6. The rationale for its decision;
7. References to evidence or documentation, including the practice guidelines, considered in reaching its decision; and
8. The written opinions of the clinical review panel, if any.

If the IRO's decision is to allow benefits, within 5 business days of our receipt of the notification, we must approve the benefit as covered, subject to applicable policy exclusions, limitations and other provisions.

Expedited External Review

You may file a request for an expedited external review within 15 days after receiving a notice of a denied claim if you meet the requirements under Standard Review listed above in paragraph 2 or if the denial concerns an admission, availability of care, continued stay or health care service for which you received Emergency Medical Care, but have not been discharged from a Facility, if you may be held financially responsible for the Emergency Medical Care.

When we receive your request for an expedited external review, we will assign your review to an IRO and forward your records by overnight delivery, or tell you in writing that your situation doesn't meet the requirements for an external review and explain the reasons.

No more than three business days after it receives your request for an expedited external review, the IRO must provide a notice of its decision to you and us. If the IRO's decision is to allow benefits, we must approve the benefit as covered, subject to applicable policy exclusions, limitations and other provisions.

All requests for external review will be at our expense.

I. OTHER POLICY PROVISIONS

1. **Claim Forms:** When we receive notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not provided to you within 15 days, you will meet the Proof of Loss requirement by giving us a written statement of the nature and extent of the loss within the time limits stated in the Proofs of Loss provision.
2. **Conformity with State Statutes:** Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the state in which it is delivered on that date is amended to conform to the minimum requirements of such laws.
3. **Entire Policy; Changes:** This Policy, together with the application and any rider, endorsement or amendment, is the entire Policy between you and Blue Cross and Blue Shield of South Carolina. No independent insurance agent, broker or producer or employee of Blue Cross and Blue Shield of South Carolina can change it in any way. Only an officer of ours can approve a change. That change must be shown on your Policy.
4. **Governing Law:** This Policy and all endorsements and amendments issued hereunder will be construed according to and controlled by the applicable laws and regulations of the State of South Carolina.
5. **Grace Period:** This Policy has a 31-day grace period for the payment of premium. 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 the premium has not been paid by 12:01 a.m. of the day following the end of the Grace Period, the Policy will automatically terminate as of the premium due date without further notice to you.
6. **Illegal Occupation:** We will not provide benefits for any loss that result from the Member committing, or attempting to commit a felony or from a Member engaging in an illegal occupation.
7. **Intoxicants and Narcotics:** We will not provide benefits for any loss resulting from the Member being legally intoxicated or impaired, by being under the influence of alcohol, any narcotic or drug unless taken on the advice of a Physician. The Member or Member's representative must provide any available test results, upon our request, showing blood alcohol or drug levels. If the Member refuses to provide these test results, no benefits will be paid.

8. **Legal Actions:** No legal action may be brought to recover on this Policy until 60 days after we have received a claim (notice and proof of loss) as required by this Policy. You can not bring any such action after six years from the time you are required to give written proof of loss.
9. **Meetings of Insured Persons:** While this Policy is in force, you are a member of Blue Cross and Blue Shield of South Carolina. You are entitled to vote at any meeting of members. Our annual meeting is held at our Home Office in Columbia, South Carolina, on the first Thursday of April. Notice of the annual meeting is given by your acceptance of this Policy. We will mail you notice of any special meeting of members 30 days before such meeting.
10. **Misstatements:** If the age of a Member has been misstated and if the amount of the premiums is based on age, an adjustment in premiums, coverage, or both, will be made based on the Member's true age. No misstatement of age will continue insurance that has been otherwise validly terminated or terminate insurance otherwise validly in force. This Policy is issued to individuals from birth up to 64½ years of age or Medicare eligibility, whichever occurs first.
11. **Non-Assessable:** This is a Non-Assessable Policy. You, the Policyholder, are not subject to any assessment for any contingent liability. This means that if, for any reason, we owe money, you are not responsible for paying it.
12. **Notice of Claim:** You must give written notice of a claim within 20 days after a covered loss starts or as soon as reasonably possible. The notice may be given to us at our home office or to our agent. Notice should include the name of the Member and the Policy number.
13. **Other Valid Coverage; Proration:** This Policy is not meant to duplicate other valid coverage you have with other Health Insurance policies. "Other Valid Coverage" is Health Insurance coverage that is similar to the coverage provided by this Policy, coverage provided by hospital or medical service organizations, coverage provided by union welfare plans or employee benefit organizations, but not group or individual Health Insurance with us.

This Policy does not coordinate with other Health Insurance you may have. If you have Other Valid Coverage that we have not been given written notice prior to incurring the claim, we will "prorate" benefit payments when your claim is received. We will carefully consider all of the valid Health Insurance that covers your claim. We will determine the amount that this Policy will reimburse for your claim in proportion to the responsibility that should be accepted by other insurance companies, and we will pay the portion of your claim we determine we are responsible for.

If your claim is prorated, the portion of the premiums you paid for coverage that we did not accept as our responsibility will also be prorated. This will be based on premiums paid during the time you had Other Valid Coverage and received covered benefits.

14. **Payment of Claims:** We will pay benefits as described in this Policy directly to the Provider if we have a written agreement for direct payment of benefits with that Provider. In all other situations, we will pay directly to the Policyholder when we receive written proof of loss. The Policyholder is expressly prohibited from assigning any benefits due unless we determine otherwise.
15. **Physical Examinations:** We have the right to have a Physician examine any person as often as reasonably necessary while a claim is pending or after our Medical Services staff has been contacted for review of medical services. We will pay for the cost of these examinations. We may also have an autopsy done during the period of contestability unless prohibited by law. The autopsy must be performed in South Carolina.
16. **Proofs of Loss:** You must give written proof of loss to us within 90 days after the date of such loss. Failure to furnish such proof within the time required won't invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event, except in the absence of legal capacity, will written proofs of loss be furnished later than one year from the time the proof is otherwise required.
17. **Reinstatement:** If any renewal premium is not paid within the Grace Period, the Policy will lapse automatically without further notice to you. We may reinstate the Policy, in our sole discretion, if:
 - a. You complete an application for reinstatement; and
 - b. The unpaid premium is not more than 60 days overdue; and
 - c. You pay all overdue premiums (note: you will be given a conditional receipt for the premium); and
 - d. You furnish evidence of insurability, if required; and
 - e. We approve your request for reinstatement.

If your request is approved, the Policy will be reinstated on the date the Policy lapsed. Lacking such approval, the Policy will be reinstated on the 45th day after the date of the conditional receipt unless we have previously written you of our disapproval. The Policy will be reinstated on the date the Policy lapsed, if requirements (a) through (d) above have been met. If your request is disapproved, we will refund the premium submitted.

Reinstated insurance will provide benefits, subject to all conditions in this Policy, for:

- a. Injury sustained on or after the reinstatement date; and
- b. An illness which begins more than 10 days after the reinstatement date.

Reinstated insurance will provide benefits under any optional coverages purchased with this Policy only for services that begin after the date of reinstatement. After the Policy is reinstated, you and Blue Cross will have the same rights as existed just before the due date. Any riders, amendments or endorsements to the Policy will still apply and remain effective after reinstatement.

18. Right of Recovery

Whenever we have made overpayments or mistakes in payment, we will have the right to recover such overpayments and correct those mistakes in payment, in our sole discretion, from any person to or for with respect to which such payments were made, by check, wire transfer or as an offset against existing or future benefits payable under this Policy, and any from other insurance companies or any other organizations.

19. Right to Transfer: If you buy an individual accident, health or accident and Health Insurance policy, you 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.

20. Subrogation Right:

If you receive medical benefits under this Policy for an injury caused by the act or omissions of a liable third party and receive a settlement, judgment, or other payment relating to the injury from a liable third party, any other person, firm, corporation, organization or business entity, you agree to reimburse us for benefits that we have paid relating to the injury. This agreement is a condition to receiving benefits under this Policy. Our right to subrogation or reimbursement applies to any judgment and/or settlement proceeds, whether or not liability is admitted.

Our interest in subrogation or reimbursement extends to all benefits relating to your injury even if claims for those benefits have not been submitted to us for payment at the time you receive the settlement, judgment or payment.

You have the right to petition the Director of Insurance, or his designee, to determine if our subrogation action is inequitable or unjust. If the Director makes the determination that allowing subrogation is inequitable or unjust, then it is not allowed. This determination by the Director may be appealed to the Administrative Law Judge Division as provided by law.

We will pay attorney's fees and costs from the amount recovered.

If you choose not to pursue an action to recover damages, you agree to transfer all rights to recover damages in full for such benefits to us. At our expense, we lawfully stand in your place to recover the amount of money we have paid for your medical benefits from any third party who is liable, responsible, or otherwise makes a payment for your injury. We may seek recovery for our payment of claims from the liable third party, any liability or other insurance covering the liable third party or from your own uninsured motorist insurance and/or underinsured motorist insurance.

In all situations involving subrogation, you agree that you shall not do anything to hinder or slow our right to seek reimbursement. You shall cooperate with us, sign any documents, and do all things necessary to protect and secure our subrogation and reimbursement rights.

20. Time Limit On Certain Defenses: If any fact about a person to whom the insurance relates has been misstated, stated in error, mistakenly stated or omitted from the Application, for whatever reason, whether intentionally or not, then the true and correct facts will be used to determine whether the insurance will be rescinded, or remain in force, with or without a rider. A rider may be issued based upon misstatements, errors or mistakes made in the Application and not disclosed or revealed prior to the Effective Date of the Policy. After two years from the issue date 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.

21. Time of Payment of Claim: Indemnities payable under this Policy for any loss will be paid upon receipt of due written proof of such loss.

22. Unpaid Premium: When we pay a claim, we may deduct any premium due from the claim payment.

AMENDMENT TO THE PERSONAL BLUESM POLICY

(Policy form numbers listed below)

Health Care Reform Amendment

This Amendment is subject to all the provisions of the Personal Blue Policy, form number listed below, which are not otherwise specified in the provisions of this Amendment.

12100M-A, 12326M-A, 12130M-A, 12133M-A, 12099M-A, 12327M-A, 12136M-A, 12139M-A, 12992M-A, 12994M-A, 13034M-A, 13036M-A, 13038M-A, 13040M-A, 12221M-A and 12906M-A

This Amendment to the Policy is effective on or after the Benefit Period of your Policy starting October 1, 2010.

The Policy is revised as follows:

Preventive Benefits

Preventive Benefits is deleted in its entirety and the following substituted:

Preventive Screenings are covered according to the following:

- The United States Preventive Services Task Force (USPSTF) recommended Grade A or B screenings.
- Immunizations as recommended by the Center for Disease Control (CDC).
- Screenings recommended for children and women by Health Resources and Services and Administration.
- Preventive prostate screenings and lab work according to the American Cancer Society (ACS) guidelines

These services are provided In-network only.

Pre-existing Condition Limitation

Any reference to the Policy's Pre-Existing Condition Limitation will not apply to a Covered Person/Member who obtained coverage prior to age 19.

Lifetime Maximum

All references to Lifetime Maximums are removed.

Benefit Period Maximum

Any references to Benefit Period maximums for essential health benefits have been deleted. Benefit Period Maximums for non-essential health benefits remain. In addition, the Policy will have a \$750,000 Benefit Period Maximum for essential health benefits. Beginning on your next Benefit Period after September 22, 2011, the Benefit Period Maximum will be \$1, 250,000. Then beginning on the next Benefit Period after September 22, 2012, the Benefit Period Maximum will be \$2,000,000.

Rescissions

Any references in the policy to coverage being rescinded due to a person misstating the facts on the application for insurance are revised to state the following: Coverage may only be rescinded when the covered person has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material facts related to insurability.

Dependent Child

The definition of Dependent is revised to the following:

Dependent: Your lawful spouse and children through age 25. Dependent children are natural or adopted children, stepchildren, foster children or children who are under your legal guardianship or for whom a court order requires you to provide Health Insurance.

The Policy is further revised to remove all references to Full-time Student and all dependent age references are revised to state through age 25.

Internal (Appeals) Review

The following Definitions are added:

Post-service Claim: Any claim that is not a Pre-service Claim or any claim that is submitted to the Company after the medical care, service or supply has been provided.

Pre-service Claim: Any claim or request for a Benefit where prior authorization or Approval must be obtained from the Company before receiving the medical care, service or supply. An Approval means only that a service is Medically Necessary for treatment of a Covered Person/Member's condition, but is not a guarantee or verification of Benefits. Payment is subject to Covered Person/Member's eligibility, Pre-existing Condition Limitations and all other Contract limitations and exclusions. Final Benefit determination will be made when the Company processes the Covered Person/Member's claim.

Urgent Care Claim: Any claim made by the Covered Person/Member or by a Provider or Physician (with knowledge of the Covered Person/Member's current medical condition), where, if the normal Pre-service Claim review time frames of this Contract were used:

- a. The Covered Person/Member's life, health or ability to regain maximum function could be seriously jeopardized; or
- b. The Covered Person/Member, in the opinion of the Physician, would be subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The *Appeals* Section of your policy is deleted in its entirety and replaced with the following:

There are three types of claims. They are Pre-service Claims, Urgent Care Claims (a type of Pre-service Claim) and Post-service Claims. The time frames allowed for the Company to provide a determination for each of these claims are listed below:

- a. Pre-service Claim – A determination, based on Medical Necessity, must be provided in writing or in electronic form within 15 calendar days.

An extension of 15 calendar days may be provided if the Company determines that for reasons beyond the control of the Company, an extension is necessary. If an extension is required, the Company will notify the Covered Person/Member within the initial 15-day time period that an extension is necessary.

If the Company receives incomplete information from the Covered Person/Member and additional information is required to make a determination, the Covered Person/Member will be notified within five calendar days. The Covered Person/Member has 60 calendar days to provide the required information. If the Company does not receive the required information within the 60-day time period, the claim may be denied.

When the Company requires an extension due to incomplete information, the Company is entitled to the rest of the initial determination period to reach a Benefit determination after the additional information is received from a Covered Person/Member or Provider.

- b. Urgent Care Claim – A determination, based on Medical Necessity, must be provided to the Covered Person/Member in writing or in electronic form within 24 hours of the original Urgent Care Claim. A Provider may be considered an authorized representative without a specific designation by the Covered Person/Member when the Approval request is for Urgent Care Claims (medical conditions which require immediate treatment).

The Company will notify the Covered Person/Member or his authorized representative of the lack of information from which to render a decision within 24 hours from receipt of the original Urgent Care Claim. An extension of 48 hours may be required if the Company does not receive complete information in which to make a Medical Necessity decision. If the Company does not receive the required information from the Covered Person/Member within 48 hours after notifying the Covered Person/Member, the claim may be denied.

- c. Post-service Claim – A determination must be provided to the Covered Person/Member in writing or in electronic form within 30 calendar days if the decision is adverse to the Covered Person/Member. An adverse decision includes any amount due that the Covered Person/Member may be held responsible for other than Copayment amounts previously paid to the Provider or any rescission of coverage

An extension of 15 calendar days may be provided if the Company determines that for reasons beyond the control of the Company, an extension is necessary. If an extension is required, the Company will notify the Covered Person/Member within the initial 30-day time period that an extension is necessary.

If the Company receives incomplete information from the Covered Person/Member and additional information is required to make a determination, the Covered Person/Member will be notified within 30 calendar days. The Covered Person/Member has 60 calendar days to provide the required information. If the Company does not receive the required information within the 60-day time period, the claim may be denied.

When the Company requires an extension due to incomplete information, the Company is entitled to the rest of the initial determination period to reach a Benefit determination after the additional information is received from a Covered Person/Member or the Provider.

- d. Concurrent Care Decision – If the Company makes a decision to reduce or stop Benefits for Concurrent Care that had previously been approved, the Covered Person/Member must be notified sufficiently in advance of the reduction or termination of Benefits to allow the Covered Person/Member time to appeal the decision before the Benefits are reduced or terminated.

If the Covered Person/Member requests that Concurrent Care Benefits be extended and the request involves urgent care, the request to extend a course of treatment beyond the initially approved period of time or number of treatments must be made at least 24 hours prior to the expiration of the initially approved period. The Company must make a decision within 24 hours.

Appeal Process

If a Covered Person/Member wishes to file a formal **appeal**, the Covered Person/Member must write to Blue Cross and Blue Shield of South Carolina, Member Service Center, P.O. Box 100300, Columbia, SC 29202. The letter must state that a formal appeal has been requested and all pertinent information regarding the claim in question must also be included in the letter.

Requests to cover services and supplies which are specifically excluded in the Contract will not be treated as appeals and such requests will not be forwarded to the Claims Review Committee. The following guidelines apply for each type of claim (including the appropriate claim with regard to a Concurrent Care decision), unless both parties agree to an extension:

- a. Pre-service Claim – The Covered Person/Member has 180 days to appeal the Company's decision on a Pre-service Claim or a Concurrent Care decision. The Company must complete the appeal process within 15 calendar days after receiving the appeal. If the Covered Person/Member still does not agree with the Company's decision, the Covered Person/Member can file a second appeal within 90 days after receiving the Company's decision on the first appeal. The Company must complete the second appeal process within 15 calendar days after receiving the second appeal.
- b. Urgent Care Claim – The Covered Person/Member has 180 days to appeal the Company's decision on an Urgent Care Claim. The Company must complete the appeal process within 72 hours after receiving the appeal.
- c. Post-service Claim – The Covered Person/Member has 180 days to appeal the Company's decision on a Post-service Claim. The Company must complete the appeal process within 30 calendar days after receiving the appeal. If the Covered Person/Member still does not agree with the Company's decision, the Covered Person/Member can file a second appeal within 90 days after receiving the Company's decision on the first appeal. The Company must complete the second appeal process within 30 calendar days after receiving the second appeal.

Nothing contained in this Amendment will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the Policy other than as stated above.

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(www.SouthCarolinaBlues.com)



James A. Deyling
President

Blue Cross and Blue Shield Division

AMENDMENT TO THE PERSONAL BLUESM POLICY

(Policy form numbers listed below)

NSA Amendment

This Amendment is subject to all the provisions of the Personal Blue Policy, form number listed below, which are not otherwise specified in the provisions of this Amendment.

12100M-A, 12326M-A, 12130M-A, 12133M-A, 12099M-A, 12327M-A, 12136M-A, 12139M-A, 12992M, 12994M, 13034M, 13036M, 13038M, and 13040M

This Amendment is a supplement to the Policy and is effective on or after April 1, 2010.

The Policy is revised as follows:

Section B. Definitions, is revised by the deletion of **Prescription Drug** and the following substituted:

Prescription Drug: A drug that has been approved by the FDA and labeled "Caution: Federal Law Prohibits Dispensing Without Prescription," or labeled in a similar manner. Only a licensed registered pharmacist can dispense it according to a Physician's prescription order. Injectable insulin is also included.

Brand-name Drug: A Prescription Drug that is manufactured under a registered trade name or trademark. A Brand-name Drug may be a Preferred Drug or a Non-preferred Drug.

Generic Drug: A Prescription Drug that has the same active ingredients as the Brand-name Drug but is not manufactured under a registered brand name or trademark.

Non-preferred Drug: A Prescription Drug that has not been chosen by us, or our designated Pharmacy Benefit Manager, to be a Preferred Drug. This includes any Brand-name Drug with an "A" rated Generic Drug available.

Preferred Drug: A Prescription Drug that has been reviewed for cost, clinical effectiveness and quality. Preferred Drugs are Brand-name Drugs and Generic Drugs that are preferred by us, or our designated Pharmacy Benefit Manager, for dispensing to Members when appropriate. The Preferred Drug List is subject to periodic review and updates by us, or our designated Pharmacy Benefit Manager, without notice.

Specific classes of Over-the-counter Drugs may be covered as Prescription Drugs. If the Policy to which the Amendment is attached includes coverage for specific Over-the-Counter Drugs, it will be shown on the Schedule of Benefits. You must have a valid prescription for these classes of Over-the-counter Drugs.

Section C. Covered Services, is revised by the deletion of **Prescription Drugs** and the following substituted:

Prescription Drugs – We'll provide benefits for Prescription Drugs as specified in the Schedule of Benefits.

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 in the current *Physician's Desk Reference* or as recommended under the guidelines of our Pharmacy Benefit Manager, whichever is lower.

We treat insulin as a Prescription Drug whether it's injectable or otherwise. Prescription Drugs don't include devices of any type, except contraceptive devices when shown on the Schedule of Benefits; artificial appliances; vitamins; infertility drugs; drugs for treatment of sexual dysfunction; Medical Supplies (Medical Supplies are paid under the regular Policy benefits); food supplements; Prescription Drugs for which there is an Over-the-counter Drug equivalent (except for Over-the-counter Drugs that are required as part of a Step Therapy Program), Prescription Drugs used for or related to weight control, obesity, cosmetic purposes (such as Tretinoin or Retin-A), hair growth, hair removal, smoking cessation, Over-the-counter Drugs (except for Over-the-counter Drugs that are required as part of a Step Therapy Program) and Over-the-counter devices, supplies or supplements.

Specific classes of Over-the-counter Drugs may be covered as Prescription Drugs. If the Policy to which this Amendment is attached includes coverage for specific Over-the-counter Drugs, it will be shown on the Schedule of Benefits. You must have a valid prescription for these classes of Over-the-counter Drugs.

Prescription Drugs must be dispensed in a licensed Pharmacy. Eligible Prescription Drugs don't include drugs obtained from a "virtual office visit." A "virtual office visit" occurs when the Physician treating, consulting, diagnosing, writing or approving a prescription has never physically seen or physically examined the Member.

The Pharmacy Benefit Manager (PBM) for us and some of our subsidiaries, contracts with and manages the Pharmacy network, negotiates prices with the Contracting Pharmacies and performs other administrative services. We receive financial credits directly from drug manufacturers and through our Pharmacy Benefit Manger (PBM). These credits are used to help stabilize overall rates and to offset costs. Reimbursements to Pharmacies or discounted prices charged at Pharmacies, are not affected by these credits.

Any Coinsurance percentage that you must pay for Prescription Drugs is based on the Allowable Charge at the Pharmacy and doesn't change when we receive any financial credit. Copayments are flat amounts and likewise don't change when we receive drug manufacturer or PBM credits.

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. If you don't get the required Preauthorization, no benefits will be provided.

You may be required to try certain drugs to treat your medical condition before we'll cover another drug for that condition. This is called Step Therapy. If the Step Therapy program is not followed, your prescription will not be covered.

Specialty Drugs are covered only if shown in the Schedule of Benefits.

Benefits won't be provided or paid for the following:

1. Service charges or handling fees for a Prescription Drug;
2. More than the number of days supply shown on the Schedule of Benefits;
3. Prescription refills in excess of the number specified on the prescription or refills dispensed more than one year after the original prescription date;
4. Prescription Drugs for Pre-existing Conditions or Ridereed conditions; or
5. Prescription Drugs that are not Medically Necessary.

You must pay the Pharmacy at the time your prescription is filled.

When you buy drugs from a Contracting Pharmacy you must show the pharmacist your Blue Cross ID card. The pharmacist will know not to charge you more than the Allowable Charge for the drugs.

This Policy may not provide benefits at a non-Contracting Pharmacy. If benefits are available at a non-Contracting Pharmacy, it will be shown in the Schedule of Benefits. If benefits are available, Non-Contracting Pharmacies can charge you more than the Allowable Charge. Benefits for drugs purchased from non-Contracting Pharmacies will be paid at a lower percentage.

If you purchased the Drug Card, you (or your covered Dependent) must pay the Contracting Pharmacy:

1. The Prescription Drug Deductible, if applicable; and
2. The Prescription Drug Copayment or the Contracting Pharmacy's usual, reasonable and customary charge that would be charged to a non-Member, whichever is less; and
3. Any type of service charge including the administration or injection of a Prescription Drug; or
4. 100% of the cost of a Prescription order when a Member fails to show his or her identification card.

If a Contracting Pharmacy is not used and your benefits include coverage for a Non-Contracting Pharmacy, you (or your covered Dependent) must:

1. Pay the Pharmacy in full for the Prescription Order; and
2. File a claim form with us for reimbursement. The claim form must be obtained from us.

Nothing contained in this Amendment will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the Policy other than as stated above.

The Effective Date of this Amendment is the Effective Date of the Policy to which it is attached or the Amendment date, whichever is later.

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James A. Deyling
President

Blue Cross and Blue Shield Division

AMENDMENT TO THE PERSONAL BLUESM POLICY
(Policy form numbers listed below)

Student Amendment

This Amendment is subject to all the provisions of the Personal Blue Policy, form number listed below, which are not otherwise specified in the provisions of this Amendment.

12100M-A, 12326M-A, 12130M-A, 12133M-A, 12099M-A, 12327M-A, 12136M-A, 12139M-A, 12104M-A, 12328M-A, 12106M-A, 12329M-A, 12992M-A, 12994M-A, 13034M-A, 13036M-A, 13038M-A, 13040M-A, 12221M-A, 12906M-A and 12791M-A

This Amendment is a supplement to the Policy and is effective on or after November 1, 2009.

The Policy is revised as follows:

Section B. Definitions, is revised by the deletion of **Full-time Student** and the following substituted:

Full-time Student: A Dependent child age 22 or younger and enrolled in and attending one of these:

- a. High school; or
- b. An accredited or licensed school commonly recognized as a vocational, technical or trade school, with attendance qualifying the Dependent child as a full-time student under the rules of the institution; or
- c. A college or university with full enrollment in at least enough regular academic courses to reach the status of a full-time student at the institution.

Periods between school terms, such as summer periods, will be included if the child was attending as a Full-time Student during the last regular school term session. Correspondence-course participation does not constitute attendance as a Full-time Student.

A time period between graduation from high school and vocational, technical or trade school or college entry, or between college graduation and graduate school entry, will be included only if the child has applied for admission beginning with the next regular school term or session immediately following graduation.

You must send us a letter stating the Dependent child is a Full-time Student. Your letter must include a tuition receipt from the school's Bursar's office or a letter from the school verifying its accreditation and the student's full-time status.

A Dependent child who is a Full-time Student on the day prior to beginning a Medically Necessary Leave of Absence may remain covered under this health plan until the earlier of: 1) one year from the first day of the Medically Necessary Leave of Absence; or 2) the date on which the coverage would otherwise terminate under the terms of the Policy.

A Dependent child must enroll as a Full-time Student the next regular term following the end of a Medically Necessary Leave of Absence to remain classified as a Full-time Student.

Section B. Definitions, is revised by the addition of the following definition:

Medically Necessary Leave of Absence: Occurs when a Full-time Student stops attending school, or drops to part-time attendance, due to a serious illness or injury that prevents full-time attendance. We must receive documentation from the Full-time Student's treating Physician certifying that he or she is suffering from a serious illness or injury and that the leave of absence is Medically Necessary.

Nothing contained in this Amendment will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the Policy other than as stated above.

The Effective Date of this Amendment is the Effective Date of the Policy to which it is attached or the Amendment date, whichever is later.

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James A. Deyling
President

Blue Cross and Blue Shield Division

AMENDMENT TO THE PERSONAL BLUESM POLICY
(Policy form numbers listed below)

Amendment

This Amendment is subject to all the provisions of the Personal Blue Policy, form number listed below, which are not otherwise specified in the provisions of this Amendment.

12100M-A, 12326M-A, 12130M-A, 12133M-A, 12099M-A, 12327M-A, 12136M-A, 12139M-A, 12221M-A and 12906M-A

This Amendment is a supplement to the Policy and is effective on or after September 1, 2011.

The Policy is revised as follows:

Section B. Definitions, is revised by the deletion of **Durable Medical Equipment** and the following substituted:

Durable Medical Equipment: Equipment your doctor orders that has exclusive medical use. These items must be reusable and may include wheelchairs, hospital-type beds, walkers, oxygen tanks, respirators, etc. To qualify for benefits, your Physician must order the medical equipment and it must be Medically Necessary for a specific need. Equipment such as air conditioners, whirlpool baths, spas, (de)humidifiers, wigs, fitness supplies, vacuum cleaners or air filters do not qualify because they do not have exclusive medical uses. To be considered Durable Medical Equipment, the device or equipment's use must be limited to the patient for whom it was ordered. This means others cannot use the device or equipment.

Section B. Definitions, is revised by the deletion of **Hospice Care** and the following substituted:

Hospice Care: A program of care for terminally ill people who are not expected to live more than six months.

Section B. Definitions, is revised by the deletion of **Orthotic Devices** and the following substituted:

Orthotic Devices: Special devices such as splints, cervical collars, back braces or hip-knee-ankle or foot orthosis used to treat problems of the muscles, ligaments, connective tissues or bones of the skeletal system. Orthotic Devices does not include adjustable cranial orthosis (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling surgery.

Section B. Definitions, is revised by the deletion of **Physician** and the following substituted:

Physician: A person (other than an intern, resident or house Physician), duly licensed as a medical doctor, oral surgeon, dentist, osteopath, podiatrist, chiropractor, optometrist, ophthalmologist, Physician's assistant or licensed doctoral psychologist, legally entitled to practice within the scope of his or her license and who normally bills for his or her services.

Section B. Definitions, is revised by the deletion of **Prosthetic Appliances** and the following substituted:

Prosthetic Devices: Artificial replacement body parts needed to ease or correct a condition caused by an illness, injury or birth defect, disease or anomaly. A Physician must order the appliance or device and we must determine it to be Medically Necessary. Prosthetics do not include bioelectric, microprocessor or computer programmed prosthetic components.

Section B. Definitions, is revised by the addition of the following:

Serious Medical Condition: A health condition or illness that requires medical attention, and for which failure to provide the current course of treatment through the current Provider would place your health in serious jeopardy. This includes cancer, acute myocardial infarction and pregnancy.

Section D. Covered Services, is revised by the deletion of **first three paragraphs** and the following substituted:

Benefits for Covered Services will be paid according to the provisions described in this Policy. Benefit payments are based on a percentage of Allowable Charges and are subject to Deductibles, Copayments and Benefit Period Maximums as shown on the Schedule Page.

Covered Services include only the services and supplies described below to the extent the charges are not limited or excluded in any provisions of this policy. The services and supplies must:

1. Be prescribed by or performed by or upon the direction of a Physician; and
2. Be done for diagnosis or treatment of a Covered Person's illness or injury, except as specifically noted herein; and
3. Be approved as Medically Necessary and appropriate; and

4. Not be Investigational or Experimental in nature; and
 - Uses of allogeneic bone marrow transplantation (between two related or unrelated people) or syngeneic bone marrow transplantation (from one identical twin to the other) along with other forms of stem cell transplant (with or without high doses of chemotherapy or radiation) in cases in which less than four of the six complex antigens match; cases in which mixed leukocyte culture is reactive; and AIDS and HIV infection;
 - Adrenal tissue to brain transplants;
 - Islet cell transplants;
 - Procedures that involve the transplantation of fetal tissues into a living recipient; and
5. Not be for charges for services or supplies from an independent health care professional whose services are normally included in Facility charges;
6. Not be for pre-conception testing, pre-conception counseling or pre-conception genetic testing;
7. Be for which you are legally responsible for paying and not for luxury or convenience; and
8. Be provided after the Effective Date and before the termination of coverage, unless otherwise specified.

Covered Services do not include treatment for complications resulting from any non-covered procedure or condition, acupuncture, hypnotism or travel expenses.

Section D. Covered Services, is revised by the deletion of **Complications of Pregnancy** and the following substituted:

Complications of Conditions due to Pregnancy – A life-threatening condition needing medical treatment during or after a pregnancy. The condition must be diagnosed as separate or distinct from the pregnancy but caused or exacerbated by the pregnancy. An elective abortion is not considered a Complication of Pregnancy.

Section D. Covered Services, is revised by the deletion of **Dental Services Related to Accidental Injury** and the following substituted:

Dental Services to Sound Natural Teeth – Care for the treatment, Surgery or appliances caused by accidental bodily injury (except dental injuries occurring during the natural act of chewing). Benefits are limited to care completed within six months of such accident and while the patient is still covered under this Certificate.

Section D. Covered Services, is revised by the deletion of **Durable Medical Equipment, Prosthetic Appliances and Orthotic Devices** and the following substituted:

Durable Medical Equipment – If a Physician prescribes Durable Medical Equipment and it is Medically Necessary for the treatment of the member's condition, then we will provide benefits for the purchase price or the total rental cost up to the purchase price for Durable Medical Equipment as shown in your Schedule of Benefits. Please refer to your Schedule of Benefits to see what benefit limitations apply. We will provide benefits for deluxe/specialized equipment at the standard equipment allowance. The rental benefits cannot exceed the purchase price of the equipment. Preauthorization and Approval is required when the purchase price or total rental cost is more than the amount shown in the Schedule of Benefits. Benefits do not include a TENS unit; or manual or motorized wheelchairs or power operated scooters for mobility outside the home setting. We must determine the devices are Medically Necessary to assist with mobility in the home for benefits to be available. No Benefits are provided for repair, replacement or duplicates, nor are benefits provided for services related to the repair or replacement of DME, except when necessary due to a change in the Member's medical condition, and with prior authorization from us. Repair or replacement for routine wear and tear is not a covered expense.

Section D. Covered Services, is revised by the deletion of **Home Health Care Services** and the following substituted:

Home Health Care Services – When provided to a homebound Member in the Member's home. Home Health Care must be provided by, or through a community home health agency, must be provided on a part-time visiting basis and must be provided according to a Physician-prescribed course of treatment. Preauthorization based on established Home Health Care treatment must be obtained from us before you are eligible. Please refer to your Schedule of Benefits to see what benefit limitations apply. Home Health Care includes:

1. Services by a registered nurse (RN) or licensed practical nurse (LPN);
2. Physical, speech and occupational therapy (the short-term therapy Benefit Period Maximum applies)
3. Services provided by a home health aide or medical social worker;
4. Nutritional guidance;
5. Diagnostic services;
6. Administration of Prescription Drugs;
7. Medical and surgical supplies;
8. Oxygen and its use; and
9. Durable Medical Equipment (A separate Preauthorization Review is not needed when we approve the entire Home Health Care plan).

Section D. Covered Services, is revised by the deletion of **Hospice Care** and the following substituted:

Hospice Care – We must Preauthorize Hospice Care before you are eligible for this care. Benefits are payable as specified in the Schedule of Benefits. The services must be provided according to a Physician prescribed treatment plan. Please refer to your Schedule of Benefits to see what benefit limitations apply. Hospice Care includes:

1. Services provided by a registered nurse (RN) or licensed practical nurse (LPN);
2. Physical, speech and occupational therapy (the short-term therapy Benefit Period Maximum applies)
3. Services provided by a home health aide or medical social worker;
4. Nutritional guidance;
5. Diagnostic services;
6. Administration of Prescription Drugs;
7. Medical and surgical supplies;
8. Oxygen and its use;
9. Durable Medical Equipment (A separate Preauthorization Review is not needed when we approved the entire Hospice Care plan);
10. Respite care; and
11. Family counseling concerning the patient's terminal condition.

Section D. Covered Services, is revised by the deletion of **Mental Health Services and/or Substance Abuse Care** and the following substituted:

Mental Health Services and/or Substance Abuse Care – We will provide benefits as shown in the Schedule of Benefits, for Mental Health Services and/or Substance Abuse care when a Member is a patient in a Hospital or Psychiatric/Substance Abuse Facility or is receiving Outpatient services. Mental Health Services and/or Substance Abuse care do not include conditions related to attention deficit disorder, learning disabilities, behavioral problems or Inpatient confinement for environmental changes; marriage, family or child counseling for the treatment of premarital, family or child relationship dysfunctions. It also does not include services for Animal Assisted Therapy, rTMS, Eye Movement Desensitization and Reprocessing (EMDR), behavioral therapy for solitary maladaptive habits or Rapid Opiate Detoxification.

The Benefit Period Maximum is shown in the Schedule of Benefits.

Amounts a Member pays for the Mental Health Services and/or Substance Abuse care will not apply toward the Out-of-Pocket Maximum and the payment for these services do not increase when the Out-of-Pocket Maximum is met.

All Mental Health Services and/or Substance Abuse Care must be preauthorized. If Mental Health Services and/or Substance Abuse Care are not preauthorized, the benefits will be reduced as shown in the Schedule of Benefits.

Section D. Covered Services, is revised by the deletion of first paragraph of **Physician Services** and the following substituted:

Physician Services – Benefits don't include: treatment of excessive sweating; sterilization, the reversal of sterilization, infertility or impotency treatment, treatment of sexual dysfunction, or for the enhancement of sexual performance; transsexual procedures; reduction mammoplasty for macromastia unless the Member is within 20% of the ideal body weight; charges for medicine, drugs, appliances, supplies, blood and blood products; services for chronic pain management programs (including any program developed by centers with multidisciplinary staffs intended to provide interventions needed to allow the patient to develop pain coping skills and freedom from analgesic medication dependence); varicose veins, including but not limited to, endovenous ablation, vein stripping or sclerosing solutions injection; refractive care, such as radial keratotomy, laser eye Surgery or LASIK, lamellar keratoplasty or any such procedures that are designed to alter the refractive properties of the cornea; and dorsal rhizotomy in the treatment of spasticity. Benefits also don't include the treatment of obesity or for the purpose of weight reduction or control (even in cases of morbid obesity) including, but not limited to, gastric bypass or gastric banding, intestinal bypass, liposuction, wiring mouth shut and any related procedures as well as any complications from or the reversal of such restrictive and diversionary procedures. Reconstructive procedures made necessary by weight loss and any Hospital services associated with any of the above services or procedures; or Cosmetic Surgery are also not included in these benefits. Benefits are payable for the following:

Section D. Covered Services, is revised by the deletion of fourth paragraph of **Prescription Drugs** and the following substituted:

We treat insulin as a Prescription Drug whether it's injectable or otherwise. Prescription Drugs don't include devices of any type, except contraceptive devices when shown on the Schedule of Benefits; artificial appliances; vitamins; infertility drugs; drugs for treatment of sexual dysfunction; Medical Supplies (Medical Supplies are paid under the regular Policy benefits); orthomolecular therapy including infant formula, nutrients, food supplements and external feedings when not a sole source of nutrition; Prescription Drugs for which there is an Over-the-counter Drug equivalent, Prescription Drugs used for or related to weight control, obesity, cosmetic purposes (such as Tretinoin or Retin-A), hair growth, hair removal, smoking cessation and Over-the-counter Drugs (except when specified on the Schedule of Benefits), devices, supplies or supplements. Prescription Drugs also do not include prescription drugs used for or related to growth hormone therapy for patients over 18 years of age. For patients 18 years of age or younger, growth hormone therapy is covered when a growth hormone deficiency is documented. Benefits are not available for Prescription Drugs used for or related to non-covered services or conditions.

Section D. Covered Services, is revised by the deletion of **Rehabilitation** and the following substituted:

Rehabilitation – Benefits for taking part in a multi-disciplinary, team-structured Rehabilitation program following severe neurological or physical disability are available. Benefits do not include pulmonary rehabilitation, except in conjunction with a covered lung transplant.

For these benefits to be available, you must meet these requirements:

1. A Physician must order all such care; and
2. Preauthorization and Approval in writing must be obtained; and
3. The documentation that goes with a request for a Preadmission/Preauthorization Review must have a detailed patient evaluation from a Physician. This evaluation must document to a reasonable degree of medical certainty that the patient has Rehabilitation potential, and there is belief that this patient will be able to provide self-care and carry out his or her activities of daily living.

In order for benefits to continue, all care is subject to periodic review. This review will require documentation that the patient is making substantial progress toward set goals and that there continues to be significant potential for the patient to achieve these Rehabilitation goals.

Section D. Covered Services, is revised by the deletion of **Therapy Services 1.** and the following substituted:

1. Short-Term Therapy Services – Services must be Medically Necessary, ordered by a Physician, performed by a licensed therapist and provided to promote the recovery of the Member from an illness, disease or injury.
 - a. Physical Therapy — The treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, bio-mechanical and neuro-physiological principals and devices to relieve pain, restore maximum function and prevent disability following disease, injury or loss of body part.
 - b. Occupational Therapy — Treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
 - c. Speech Therapy — Treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

The Benefit Period Maximum payment is shown in the Schedule of Benefits.

Section D. Covered Services, is revised by the addition of the following:

Orthotic and Prosthetic Devices – Coverage is provided for Orthotic and Prosthetic Devices, other than a dental or cranial prosthetic, which meets minimum specifications for the body part it is replacing regardless of the functional activity level. Coverage is provided for the standard, non-luxury item only (as determined by us). Coverage for specialty items such as bionics or microprocessor components is also limited to the cost of the standard item. Only the initial temporary and permanent prosthesis is a Covered Expense. No Benefits are provided for repair, replacement or duplicates, nor are Benefits provided for services related to the repair or replacement of such prosthetics, except when necessary due to a change in the Member's medical condition, and with prior authorization from us. Repair or replacement for routine wear and tear is not a covered expense.

The Policy is further revised by the addition of the following Section:

Section J. Continuation of Care

If a Preferred Blue[®] Provider's contract ends or is not renewed for any reason other than suspension or revocation of the Provider's license, you may be eligible to continue to receive in-network Benefits for that Provider's services.

If you are receiving treatment for a Serious Medical Condition at the time a Preferred Blue Provider's contract ends, you may be eligible to continue to receive treatment from that Provider. In order to receive this continuation of care for a Serious Medical Condition, you must submit a request to us on the appropriate form.

You may get the form for this request from us by going to the website at www.SouthCarolinaBlues.com or calling 1-800-868-2500, extension 43475. You will also need to have the treating Provider include a statement on the form confirming that you have a Serious Medical Condition. Upon receipt of your request, we will notify you and the Provider of the last date the Provider is part of our network and a summary of continuation of care requirements. We will review your request to determine if you qualify for the continuation of care. If additional information is necessary to make a determination, we may contact you or the Provider for such information.

If we approve your request, we will provide in-network Benefits for that Provider for 90 days or until the end of the Benefit Period, whichever is greater. During this time, the Provider will accept the network allowance as payment in full. Continuation of care is subject to all other terms and conditions of this Contract, including regular Benefit limits.

Nothing contained in this Amendment will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the Policy other than as stated above.

The Effective Date of this Amendment is the Effective Date of the Policy to which it is attached or the Amendment date, whichever is later.

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