PERSONAL BLUE℠ 2 SE

GROUP INSURANCE MEMBER CERTIFICATE

Schedule of Benefits for Personal BluePlan℠ 2 SE

Certificateholder's Name:	Your Name
Certificateholder's ID Number:	Your ID Number
Date of Birth:	Your Date of Birth
Type of Plan:	Single – Family Coverage Only Available With Optional Family Coverage Endorsement
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 31.
Covered Dependents:	Covered Dependent Names, if Optional Family Coverage Endorsement is Selected

Member Certificate and Premium Schedule

Ord. Number	Member Certificate Description	Premium
12897M	Personal BluePlan 2 SE	Your Premium
	Optional Dental Coverage	Your Premium or Not Purchased
13074M	Optional Family Coverage	Selected or Not Selected
	Total <u>Monthly</u> Premium	Total Premium

Schedule of Benefits for Personal BluePlan 2 SE

(continued)

Deductible – You Pay	You Chose one of the following: $250 $500 $1,000 $1,500 $2,000 $3,000 $5,000 The Deductible is Member per Benefit Period for both In-network Providers and Out-of-network Providers. The In-network Deductible applies to the Out-of-network Deductible and the Out-of-network Deductible applies to the In-network Deductible. Deductibles do not apply to the Out-of-Pocket Maximums.
Copayments – You Pay	$0 per In-Network Facility Inpatient Admission $250 per Out-of-Network Facility Inpatient Admission 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	You Chose one of the following: In-Network / Out-of-Network $1,500 / $3,000 $2,500 / $5,000 $3,000 / $6,000 $5,000 / $8,000 The Out-of-pocket Maximum is per Member per Benefit Period 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, 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 dental coverage (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. Out-of-Pocket expenses apply to both Out-of-Pocket Maximums.
Benefit Period Maximum – We Pay (All Benefit Period Maximums are 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**
Physician Services		
Physician charges for services in an Outpatient Hospital or Clinic, including Surgery, (except Mental Health Services and/or Substance Abuse Care) and Outpatient lab and X-ray services	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Deductible
Primary Care Physician (PCP) or Specialist non-routine/sick office charges to include the following: services for the treatment of an accident or injury; injections for allergy, tetanus and antibiotics; diagnostic lab and diagnostic X-ray services (such as chest X-rays and standard plain film X-rays), when performed in the Physician's office on the same date and billed by the Physician (does not include Mental Health Services and/or Substance Abuse Care)	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Deductible
Physician charges for all other services, including Surgery, Second Surgical Opinion, consultation, dialysis treatment, chemotherapy and radiation therapy and Specialty Drugs (including the administration) and the reading/interpretation of diagnostic lab and X-ray services	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Deductible
Endoscopies (such as colonoscopy, proctoscopy and laparoscopy) performed in a Physician's office, whether for diagnosis or treatment	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Deductible
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	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Deductible
Inpatient Physician charges for admissions in a Hospital and Skilled Nursing Facility, Surgery, anesthesia, radiology and pathology services	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Deductible

Schedule of Benefits for Personal BluePlan 2 SE

(continued)

	WE PAY IN-NETWORK PROVIDERS	WE PAY OUT-OF-NETWORK PROVIDERS
Preventive Benefits		
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 according to the American Cancer Society guidelines	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
Women's Preventive Health Services		
Lactation Support and Counseling. Includes breast pump when purchased through a doctor's office, pharmacy or DME supplier and is limited to one pump every 12 months.	100%	Not covered
Sterilization (female only)	100%	Not covered
The following contraceptive devices or services: generic injections, Mirena IUD, Nexplanon implant, Ortho Evra patch, Nurvaring, Ortho Flex, Ortho Coil, Ortho Flat, Wide-seal, Omniflex, Prentif and Femcap-vaginal	100%	Not covered
All Other contraceptives devices or services not specifically listed	90%, 80%, 70% or 60% after the Deductible	Not covered
Other Services		
Out-of-Country services or supplies (including Facility and Physician)	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Copayment and the Deductible
Ambulance	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Deductible
Home Health Care with the required Preauthorization	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Deductible
Inpatient and Outpatient Hospice Care with the required Preauthorization	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Deductible
Short-Term Therapy (physical, occupational and speech therapy)	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Deductible
Other Therapy Services	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Deductible

	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 $500 or more.	90%, 80%, 70% or 60% after the Deductible	Not Covered
Medical Supplies	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Deductible
Prosthetic Devices	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Deductible
Dental Care due to accidental injury to Sound Natural Teeth	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Deductible
Mental Health Services and/or Substance Abuse Care	(1) Inpatient – 90%, 80%, 70% or 60% after the Deductible (2) Outpatient/Physician's Services – 90%, 80%, 70% or 60% after the Deductible	(1) Inpatient – 70%, 60%, 50% or 40% after the Copayment and the Deductible (2) Outpatient/Physician's Services – 70%, 60%, 50% or 40% after the Deductible
Human Organ and Tissue Transplants 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.	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Deductible
Facility Benefits		
Inpatient Hospital (other than Skilled Nursing Facility or Mental Health Services and/or Substance Abuse Care)	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Copayment and the Deductible
Skilled Nursing Facility	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Deductible
Inpatient Rehabilitation services when Preauthorized by us	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Deductible
Outpatient Hospital Emergency Room charges	90%, 80%, 70% or 60% after the Deductible	90%, 80%, 70% or 60% after the Deductible
Outpatient Hospital or Clinic charges for medical and surgical services, Preadmission Testing, lab and X-ray services and all other miscellaneous services	90%, 80%, 70% or 60% after the Deductible	70%, 60%, 50% or 40% after the Deductible

Drug Card

	YOU PAY CONTRACTING MAIL SERVICE PHARMACY	YOU PAY PARTICIPATING NETWORK PHARMACY	WE PAY NON-PARTICIPATING NETWORK PHARMACY
Prescription Drugs			
Drug Card Generic, Preferred and Non-Preferred Drugs	You pay the Prescription Drug Copayment per prescription or refill of: $8 or 20%, whichever is greater for Generic Drugs 30% for Preferred Drugs 60% for Non-preferred Drugs	You pay the Prescription Drug Copayment per prescription or refill of: $8 or 20%, whichever is greater for Generic Drugs 30% for Preferred Drugs 60% for Non-preferred Drugs	Not Covered
Generic Oral Birth Control	100% per prescription or refill	100% per prescription or refill	No Benefits
Preferred and Non-Preferred Oral Birth Control	You pay the Prescription Drug Copayment of: 30% for Preferred Drugs 60% for Non-preferred Drugs Benefits are limited to a 90-day supply.	You pay the Prescription Drug Copayment of: 30% for Preferred Drugs 60% for Non-preferred Drugs Benefits are limited to a 31-day supply or a 90-day supply.	No Benefits

Benefits provided through this Drug Card uses the *Try Generics Drug List*. This is a list of brand-name drugs that have a step-therapy requirement. Before coverage is available for certain Preferred Drugs, you must first try a Generic Drug. If you don't try a generic or you don't obtain an exception (prior approval to purchase) for the Preferred Drug, no benefits will be provided for that drug.

	YOU PAY SPECIALTY DRUG NETWORK PROVIDERS	WE PAY ALL OTHER PHARMACY PROVIDERS
Specialty Drugs		
	You pay the Specialty Drug Copayment per prescription or refill of: 60% of Allowable Charges. Benefits are limited to the amount for which prior approval was given.	Not Covered

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

Dental Services

Dental Services

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.

$25 Dental Services Deductible for Classes II and III.
Benefits for dental services are limited to $500 per Member Benefit Period. All covered dental services apply to the $500 maximum payment.

Covered Services	Percentage of Allowable Charges Payable
Class I	80%
Class II	60%
Class III	40%

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How to Contact Us if You Have a Question

It is only natural to have questions about your coverage and Blue Cross® and Blue Shield® of South Carolina is committed to helping you understand your coverage so you can make the most of your benefits.

For Customer Service Inquiries
If you have any questions about your premium or eligibility, or want to change your coverage, please contact the Membership department. We can be reached by telephone, mail or through our Website.

Telephone Numbers: (Monday through Friday, 8:30 a.m. to 5:30 p.m. Eastern Standard Time)
803-264-6401 (from the Columbia area)
800-868-2500, ext. 46401 (from all other areas)

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

For Health Claim Inquiries
If you have any questions about your claims or want to file a grievance, please contact the Claims Service Center. We can be reached by telephone, mail or through our Website. 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)
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

Website
Go to www.SouthCarolinaBlues.com, then log in to "My Health Toolkit."

For Preadmission Review, Emergency Admission Review, Continued Stay Review and Preauthorizations
Please refer to the *Preauthorization and Approval* section of this Certificate for a detailed list of the services and supplies that require Preadmission, Emergency Admission or Continued Stay 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:

866-500-7664.

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 an independent company that preauthorizes certain radiological procedures.

For Preadmission, Emergency Admission or Continued Stay Review or Preauthorization for all other medical care, please call:
803-736-5990 (from the Columbia area)
800-327-3238 (from all other South Carolina locations)
800-334-7287 (from outside South Carolina)

For Preadmission, Emergency Admission or Continued Stay Review and Preauthorization of Mental Health Services and/or Substance Abuse care, call Companion Benefit Alternatives, Inc. (CBA) at:
803-699-7308 (from the Columbia area)
800-868-1032 (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.

Introduction

This Certificate summarizes and explains the benefits available to you from Blue Cross and Blue Shield of South Carolina. It includes as few legal and technical terms as possible. Your insurance is effective, subject to all provisions of this Certificate and the Master Policy.

This Certificate is not an insurance policy. This Certificate becomes part of the Master Policy. The Master Policy is also the controlling document for determining all contractual rights. In the event of differences or errors, the provisions of the Master Policy control. If you wish to review the Master Policy, please submit a written request to the membership department at the address listed in the *How to Contact Us if You Have a Question* section.

To make sure your claims are handled properly, our process involves evaluation and Preauthorization of certain services, scheduled admissions (at least 48 hours prior to admission), Emergency/Urgent admissions and Continued Stay Services. Early identification and management of health problems can help reduce health care costs. Preauthorization and Approval is required in advance for certain services, including Mental Health Services and Substance Abuse care, in order to receive maximum benefits available under this Certificate.

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 will find useful tools that can help you better understand your coverage.

Here are some of the things you can do on our Website:
- Learn more about our products and services.
- Stay informed with all the latest Blue Cross news, including press releases.
- Find links to other health-related Websites.
- Locate a network Physician, Hospital or Pharmacy.
- Use My Health Toolkit.

My Insurance Manager
Go to "My Health Toolkit" from www.SouthCarolinaBlues.com to:
- Check your eligibility.
- See how much you have paid toward your Deductible or Out-of-Pocket Maximum.
- Check on Authorizations.
- Find out if we have processed your claims.
- Order a new ID card.
- See if our records show if you have other Health Insurance.
- Ask a Customer Service Representative a question through secure email.
- View your Explanation of Benefits (EOB).

Eligibility, Coverage and When Your Coverage Ends

Important Notice Concerning Statements in Your Application for Insurance
The Application is a part of the Contract. Your Application will be mailed to you separately. We issued the Certificate 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 your Application was signed and the Effective Date of this Certificate. You have a duty to disclose updated medical and personal information from the date of the Application until the Effective Date of the Certificate. Please read the copy of the Application. If any information on it is not correct and complete as of the Certificate Effective Date, or if any medical history has not been included, write to Blue Cross and Blue Shield of South Carolina, Membership Department, Post Office Box 61153, Columbia, South Carolina, 29260. If an error on your Application is an intentional misrepresentation of material facts related to your insurability, or you perform an act or practice that constitutes fraud, we may have grounds to rescind the Certificate A rescission does not include a retroactive cancellation or discontinuance of your coverage due to the failure to timely pay premiums. If the Certificate is rescinded, we will refund your premiums minus any amounts paid for claims.

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 Certificate.

After this Certificate has been in force for two years, we can not use any statement made in any Application (unless fraudulent) to void the Certificate or deny any claim incurred after the two-year period.

Eligibility
This coverage is available through a group trust. Single-only Certificates are issued only to individuals: 1) from 19 years of age to 64½ years of age; 2) who are not Medicare eligible; and 3) who live in South Carolina. Dependents cannot be added to the Certificate.

Under this Certificate, services and supplies for the specified medical condition or symptoms will be eligible benefits subject to an additional premium and the terms and limitations of the coverage. Other prior health conditions may still be excluded by Endorsement. We have the authority to determine your eligibility to receive benefits.

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

Changes in the Deductible, Out-of-Pocket, Coinsurance or Optional Endorsement
You can apply for an increase or decrease in the Deductible, Out-of-Pocket, Coinsurance or optional Endorsement.

You must request the change in writing and your request must be for a product the Trustee offers at that time. The new premium will be based on your sex, current age and the rates in effect where you live at the time. The change will go into effect on the next premium due date after the change is approved.

For decreases in the Deductible, the new premium may be based on your health at the time of the request for Deductible change. Changes will go into effect on the next premium due date after we approve the change. Any coverage changes may be subject to underwriting. These additional rules apply:

1. Proof of good health, satisfactory to us, must be furnished.
2. Any change we approve will not apply to a loss that occurs before the Effective Date of the change. A new Benefit Period will begin on the date the change takes effect.

Premiums

The benefits described are available as long as the required premium is paid. We base initial premiums on your age, sex, where you live and various rating factors related to a specific medical condition or symptoms at the time this Certificate is issued. The Schedule of Benefits that is included with the Certificate shows the premium as of the Effective Date. Premiums change based upon the Member's age and may change if you change your place of residence. We may also change premium rates with at least a 31-day written notice.

This Certificate has a 31-day grace period for the payment of premium. 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, your coverage 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, your coverage will automatically terminate as of the premium due date without further notice to you. Any claims paid after the last premium paid date does not extend this coverage.

When we pay a claim, we may deduct any premium due from the claim payment.

If the Member's age, sex or residence has been misstated and if the amount of the premiums is based on these factors, an adjustment in premiums, coverage, or both, will be made based on the Member's true age, sex or residence. No misstatement of age will continue insurance that has been otherwise validly terminated or terminate insurance otherwise validly in force.

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 Certificate lapses due to non-payment of premiums or is non-renewed, or 3) on the Certificate Effective Date if rescinded, whichever occurs first.

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

Even if requested, we will not cancel this Certificate retroactively and refund any premium, whether or not you had any claims during that period of time except when coverage is rescinded.

Reinstatement

If any renewal premium is not paid within the grace period, the Certificate will lapse automatically without further notice to you. We may reinstate the Certificate, 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; and
d. You furnish evidence of insurability, if required; and
e. We approve your request for reinstatement.

If your request is approved, the Certificate will be reinstated on the date it lapsed. If your request is disapproved, we will refund the premium submitted.

After the Certificate is reinstated, both parties will have the same rights as existed just before the due date. Any amendments or Endorsements to the Certificate will still apply and remain effective after reinstatement.

Extension of Benefits

In the event your Certificate is terminated or not renewed, coverage may be extended for you if you are in the Hospital, Skilled Nursing Facility or are Totally Disabled on the day coverage ends. Your coverage will continue while you remain 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 Certificate maximums are met; or 3) 12 months from the termination date. We will pay benefits only for Covered Services as listed in this Certificate that are related to the treatment of the disabling medical condition.

The terms Totally Disabled/Total Disability mean you are unable to perform the duties of your occupation and are under the ongoing 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 you are 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.

In-Network Providers (Preferred Blue Providers)

The backbone of this plan 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 our 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 800-868-2500, ext. 43475 or in the Columbia area at 803-264-3475 and request a directory. Or visit our Website at www.SouthCarolinaBlues.com. Since the Preferred Blue Provider network changes all the time, it is 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 are 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 us to be Preferred Blue Providers. Those who have not are called **Out-of-Network Providers**. We make 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 Certificate 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 in 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 Allowable Charge.

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 our website at www.SouthCarolinaBlues.com or by calling 800-868-2500, extension 46401. 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.

Claims Filing

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 will 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 will need:

1. **Comprehensive Benefits Claim Form.** You can get these forms from the Claims Service Center or from our Website 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. Patient'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 cannot return them to you. Send your claims to the Claims Service Center at the address found in the *How to Contact Us if You Have a Question* section above.

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. Claims will be processed in the order we receive them and will not be reprocessed due to out of sequence dates of services.

Denial of Claims
If we deny any part or all of a claim, you will receive an Explanation of Benefits (EOB) explaining the reason(s).

If you don't understand why we denied your claim, you can:

- Read the information in this Certificate. It outlines the terms and conditions of your health coverage.
- Contact the Claims Service Center for help.
- Ask Blue Cross to let you read the group insurance Master Policy the Trustee holds for it.

Right of Recovery
We have the right to recover any overpayments or mistakes made in payment. The recovery can be from any person to or for with respect to which such payments were made. Recovery will be by check, wire transfer or as an offset against existing or future benefits payable under this Certificate, and any from other insurance companies or any other organizations.

Time Limit to Question a Claim or File a Lawsuit
You have only 180 days to question or appeal our decision regarding a claim. After that date, we will consider disposition of the claim to be final. You cannot bring any legal action against us until 60 days after we receive a claim (proof of loss) and you have exhausted the appeal process as described in the *Appeal Procedures* section of this Certificate. You cannot bring any action against us after the expiration of any applicable period prescribed by law.

DEFINITIONS

As you refer to this Certificate, please note that the words beginning with **capital letters** have special definitions. We have included the definitions of these terms under this section to help you understand your coverage. More definitions are shown in other parts of this Certificate and also in the Master Policy.

Accidental Injury: An injury directly and independently caused by a specific accidental contact with another body or object. All injuries you receive in one accident, including all related conditions and recurrent symptoms of these injuries, will be considered one injury. Accidental Injury does not include indirect or direct loss that results in whole or in part 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.

Application: A form for transmitting the necessary information from the Member to us when applying for an individual policy. This form becomes a part of this Certificate.

Approval: Medical Services or Companion Benefit Alternatives, Inc. must be called to approve the following based on Medical Necessity: Preadmission Review, Emergency Admission Review, Continued Stay Review, Preauthorization Review and Preauthorization Review for Mental Health Services and Substance Abuse care. On behalf of Blue Cross and Blue Shield of South Carolina, Companion Benefit Alternatives preauthorizes Mental Health Services and Substance Abuse services. Companion Benefit Alternatives is a separate company that preauthorizes behavioral health benefits. Medical Services is a group of medical professionals employed by us. Medical Services personnel review medical documents and also preapprove services for Medical Necessity.

Benefit Period: Your Benefit Period is either: a) a one-year period beginning on your Effective Date of your coverage and continuing for 365 days (366 days when a leap year occurs); or b) a period beginning January 1 and continuing through December 31 of each year. If option b. is selected, the Benefit Period begins on your Effective Date of coverage and continues through December 31 the first year. Your Benefit Period is shown in your Schedule of Benefits.

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

Certificate: This document, issued to a Member that summarizes the benefits and exclusions that becomes part of the group insurance Master Policy.

Certificate of Creditable Coverage: A document from a previous health insurance plan or insurer that says you had prior Health Insurance Coverage with them. You should receive a Certificate of Creditable Coverage after your prior Health Insurance Coverage ends. By presenting a Certificate of Creditable Coverage when you enroll in this new health plan, you may be able to reduce the length of or eliminate this plan's Pre-existing Condition exclusion period.

Certificateholder: You, or a parent or a legal guardian who purchased this insurance Certificate to cover the Member and who is the owner of the Certificate and payer of the premiums.

Clinic: An Outpatient Facility for examining and treating patients who are not 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 toward the Out-of-Pocket Maximum unless indicated in your Schedule of Benefits.

Continued Stay Review: The review for Medical Necessity that must be obtained from Medical Services for an extension of a previously approved Hospital or other Inpatient Facility stay.

Contracting Mammography Provider: A Provider that has a written agreement with us to provide routine mammograms. There is a separate list of mammography network Providers.

Contracting Mail-Service Pharmacy: A mail-service Pharmacy that has a written agreement with us.

Contracting Provider: Any Provider contracting with us in writing to provide services at an agreed upon rate.

Coordination of Benefits (COB): You may be covered for benefits under two or more group health plans. In this case, Blue Cross will coordinate benefits with the other plans to prevent duplicate payments and overpayments.

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 in the Schedule of Benefits.

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 the Certificate, which include Endorsements, *Exclusions and Limitations*, *Pre-existing Condition Limitations* and *Preauthorization and Approval*. The Deductible, Coinsurance and other limitations shown in your Schedule of Benefits also apply.

Credit for Prior Coverage: Benefits or coverage provided under:

1. A group health plan;
2. Health Insurance Coverage;
3. Medicare Part A or B;
4. Medicaid, other than coverage having only benefits under Section 1928;
5. Military, TRICARE or CHAMPUS;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool, including the South Carolina Health Insurance Pool (SCHIP);
8. The Federal Employees Health Benefits Plan (FEHBP);
9. A public health plan, as defined in regulations;
10. A health benefit plan of the Peace Corps;
11. Short Term Health; or
12. A State Children's Health Insurance Program (S-CHIP).

We will count the period of Credit for Prior Coverage without regard to specific health benefits covered during that time. This term does not include coverage for Excepted Benefits.

Custodial Care: Care that we determine is provided primarily to assist the patient in the activities of daily living and does not 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 you chose is shown in the Schedule of Benefits.

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 Transplant Facilities and Contracting Mammography Providers. We will not pay benefits unless a Designated Provider performs these Covered Services.

Dose: An approved quantity for a prescription or refill or single treatment of a Specialty Drug. No Dose may exceed a 31-day supply.

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.

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

Emergency Admission Review: The review for Medical Necessity that must be obtained from Medical Services within 24 hours of, or by the end of the first working day after, the commencement of an emergency admission to a Hospital or other Inpatient Facility.

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

Emergency Medical Condition: A severe illness or injury (including pain). The illness or injury must be 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 body functions; or
3. Serious damage to any organs or body parts.

Endorsement: A supplement to the Certificate that adds, limits or excludes coverage. An Endorsement may be issued based on information contained in the Application as well as other sources. An Endorsement 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 Certificate was issued, and that information would have been material to us deciding to issue the Certificate. If this Certificate is issued with an Endorsement which excludes or limits coverage for a specific condition, that condition will not be covered unless the Member requests removal of the Endorsement and we agree in writing to the removal of the Endorsement.

Excepted Benefits: Benefits or coverage provided under:
1. Coverage for accident or disability income insurance, or any combination of the two;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' Compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical Clinics;
8. Other similar insurance coverage that's specified in regulations where benefits for medical care are secondary or incidental to other insurance benefits;
9. If offered separately:
    a. Limited scope dental or vision benefits;
    b. Benefits for long-term care, nursing home care, Home Health Care, community-based care or any combination of them;
    c. Such other similar, limited benefits as specified in regulations;
10. If offered as independent, non-coordinated benefits:
    a. Coverage only for a specified disease or illness;
    b. Hospital indemnity or other fixed indemnity insurance;
11. If offered as a separate insurance policy:
    a. Medicare supplemental Health Insurance;
    b. Coverage supplement to the coverage provided under Military, TRICARE or CHAMPUS; and
    c. Similar supplemental coverage under a group health plan.

Prior coverage under any of the Excepted Benefits will not be counted as Credit for Prior Coverage.

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

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 does not 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 Coverage: Benefits for medical care provided directly through insurance, reimbursement or otherwise. It includes items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or Health Maintenance Organization (HMO) contract that a health insurer offers with the exception of those under Excepted Benefits.

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.

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

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 does not 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 rehabilitory care; or
3. For the treatment of substance or alcohol abuse; or
4. For the treatment of mental conditions.

The term Hospital does not include services in the above institutions, even when these are affiliated with or part of a Hospital.

Inpatient: A Member who is a admitted to a Hospital, Skilled Nursing Facility, Rehabilitation Facility or Psychiatric/Substance Abuse Facility per Physician orders as a registered bed patient, and is charged room and board for the stay. (This does not include Outpatient observation which may require an overnight 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 do not 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 or supply 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 has not 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 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-reviewed literature; and
5. Consultation with professionals and/or Specialists on a local and national level.

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.

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.

Member: A person insured by this Certificate.

Mental Health Services: Treatment of mental conditions. These conditions 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*. As used in this health plan, Mental Health Services does not include services for the treatment of Substance Abuse.

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.

Ostomy Supplies: Includes, but is not 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. It doesn't include any Deductibles, Copayments and Coinsurance for certain services as indicated in the Schedule of Benefits.

Under this Certificate you choose the Out-of-Pocket Maximum. The Out-of-Pocket Maximum you chose is shown in the Schedule of Benefits and on your Application.

Outpatient: A Member who receives services or supplies at a Hospital, Skilled Nursing Facility or ambulatory surgical center that does not require the Member to be admitted as Inpatient.

Over-the-Counter Drug: A drug that does not require a prescription.

Pharmacy: A Provider that is licensed to dispense medications a doctor prescribes. It does not 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.

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, 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.

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.

Preadmission Review: A review for Medical Necessity that must be obtained from Medical Services prior to all non-emergency admissions to a Hospital or other Inpatient Facility.

Preadmission Testing: Tests and studies done on an Outpatient basis that are necessary in connection with and prior to a surgical procedure. Pre-admission Testing does not include tests or studies performed to establish a diagnosis.

Preauthorization: An Approval for Medical Necessity that must be obtained from Medical Services prior to receiving certain Covered Services which are specified in the Schedule of Benefits.

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 Member's condition, but is not a guarantee or verification of Benefits. Payment is subject to 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 Member's claim.

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 Brand-Name Drug may be a Preferred Drug or a Non-Preferred Drug.

Generic Drug: A Prescription Drug that normally 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 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 includes coverage for Over-the-Counter Drugs, it will be shown in the Schedule of Benefits. You must have a valid prescription for these classes of Over-the-Counter Drugs.

Primary Care Physician: A family doctor, general Physician, pediatrician, osteopath, 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. Prosthetics do not include bioelectric, microprocessor or computer programmed prosthetic components.

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. Providers also include:

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/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/or 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.

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.

Schedule of Benefits: The pages issued to you as an attachment to the Certificate that specify the amount of coverage provided and the applicable Copayments, Coinsurance, Deductibles and limitations

Skilled Nursing Facility: A licensed institution, other than a Hospital, that has a written agreement with us or another Blue Cross and/or Blue Shield 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 is 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 skilled 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 percent 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 are not 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 is not manufactured under a registered Brand-Name or trademark.

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

Substance Abuse: The continued use, abuse and/or dependence of legal or illegal substance(s), despite significant consequences or marked problems associated with the use as defined, described or classified in the latest publication of The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*. As used in this health plan, Substance Abuse does not 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 deemed as reasonable and approved by us. This includes the usual necessary and related pre- and post-operative care.

Trustee: A person or entity, whether as original, substitute or successor, designated by Blue Cross as the group policyholder and party to any trust documents executed between it and Blue Cross.

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

a. The Member's life, health or ability to regain maximum function could be seriously jeopardized; or
b. The 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.

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

Preauthorization and Approval

To make the most of your benefits, Medical Services (a group of medical professionals employed by us who review medical documents and also preapprove services for Medical Necessity) must give advance approval for all Hospital admissions and certain other specified services. 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, PET Scans and Nuclear Cardiology exams performed in an Outpatient Facility or a Physician's office require Preauthorization by National Imaging Associates.

Preauthorization for Medical Necessity does not 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 Certificate. 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 plan requires advance Preauthorization. In-Network Providers will be familiar with this requirement and will get the necessary approvals. If you do not use an In-Network Provider, it is your responsibility to contact us before receiving services and/or supplies. If you do not 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 do not preapprove these services in writing, then we will not pay any benefits.**

If your request for Preauthorization of services is denied, you can request further review under the guidelines set out in the *Appeal Procedures* Section of this Certificate. 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 approval is not obtained, or if we do not approve the admission and you are is still admitted, we will not pay benefits for any part of the room and board charges. If a Preferred Blue Hospital or Skilled Nursing Facility does not get approval, it cannot 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 will not 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 do not expect you to wait for approval before you go to the Hospital.

Medical Services must be notified within 24 hours or by 5:00 p.m. of the next working day, if you are admitted to the Hospital as a result of the emergency room visit. If Emergency Admission Review is not obtained within the noted timeframe due to circumstances beyond your control, an appeal can be made and the admission will be reviewed based on Medical Necessity.

If Emergency Admission Review approval is not obtained within 24 hours or by the next working day, we will not pay benefits for any part of the room or board charges. If a Preferred Blue Hospital or Skilled Nursing Facility does not get approval, it cannot bill you for room and board charges. An Out-of-Network Provider, however, can bill you for the penalty.

Continued Stay Review — It is 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. We must be contacted prior to the original discharge date as determined through previous Preadmission Review or Emergency Admission Review and obtain a new determination as to whether the continuation of hospitalization or extension of the stay is approved based on Medical Necessity only.

If a Continued Stay Review approval is not obtained, or if we do not approve the continued stay but you remain in the Hospital or Skilled Nursing Facility, we will not 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 does not get approval, it cannot 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 does not get Preauthorization for you, it cannot bill you for the denied or reduced benefits due to 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 is not obtained for Inpatient Mental Health Services and/or Substance Abuse care, we will deny covered charges for room and board. If a Preferred Blue Hospital does not get approval for you, it cannot bill you for room and board charges. When approval is not obtained for Outpatient Mental Health Services and/or Substance Abuse Care, we will reduce benefits as shown in the Schedule of Benefits. If an In-Network Provider does not get approval for you, it cannot bill you for the reduction. An Out-of-Network Provider, however, can bill you for the reduction.

Do not call the Claims Service Center for Preauthorization and Approval. A Claims Service Representative cannot give approval. Please refer to the *How to Contact Us if You Have a Question* section of this Certificate 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 will talk with a medical professional. He or she will ask you for this information:
- The patient's name and ID number
- Your name and relationship to patient
- The Physician's or Provider's name, address and phone number
- The Hospital's 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 Certificate or that we will pay for the services. Payment can only be determined when your claim is submitted.

Covered Services

We will pay benefits for Covered Services according to the provisions described in this Certificate. We base benefit payments on a percentage of Allowable Charges. Benefits are subject to Deductibles, Copayments, Benefit Period Maximums, benefit limitations and exclusions as shown in the Schedule of Benefits and described in this Certificate. 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 the Master Policy or this Certificate. The services and supplies must be prescribed by or performed by, or upon the direction of, a Physician.

The following are Covered Services:

Ambulance Service – Professional ambulance services to the nearest Hospital in case of an accident or Emergency Medical Condition. Benefits are also available for transporting the sick and injured (with prior approval for Medical Necessity) between Hospitals when such Hospital is the closest Facility that can provide Covered Services appropriate to the Member's condition.

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 obdurators, 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 Certificate.

Complications of 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.

Complications of pregnancy do not include management or care for a high-risk or difficult pregnancy or vaginal delivery.

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.

Diabetes – Equipment, supplies, Outpatient self-management training and education for the treatment of Members with diabetes if it is 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. We will reduce benefits for Inpatient diagnostic services to Outpatient services when services could have been safely done on an Outpatient basis. We will provide benefits as shown in the Schedule of Benefits. 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. This does not include smear techniques;
5. Magnetic Resonance Imaging (MRI); and
6. Gastrointestinal Endoscopies

Durable Medical Equipment – If a Physician prescribes Durable Medical Equipment and it is Medically Necessary for the treatment of the patient'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**.

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, if benefits are available and specified in the Schedule of Benefits. 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).

Hospice Care – We must Preauthorize Hospice Care before you are eligible for this care, if benefits are available and specified in the Schedule of Benefits. The services must be provided according to a Physician prescribed treatment plan. The Schedule of Benefits will also indicate what benefit limitations apply. 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.

Hospital Services – Benefits do not 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; and
   c. Ancillary services.

   The day that a Member leaves a Hospital, with or without permission, is treated as the day of discharge and will not 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 and services performed at a Designated Provider. If written Preauthorization is not obtained, we will not pay benefits for any transplant procedure.

Benefits for covered transplants are subject to Deductibles and Copayments.

Organ transplant coverage includes all expenses for medical and surgical services and supplies a Member receives for human organ and/or tissue transplants while the Member is covered under this Certificate. This includes donor organ procurement. Organ transplants do not include transplants involving mechanical or animal organs.

1. The only living donor, human organ transplants covered under this Certificate are kidney transplants for Members with dialysis-dependent kidney failure and liver transplants. All other living donor, human organ transplants are not covered. Benefits will be 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 Certificate, 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 Certificate.
   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. Benefits are provided for the specified major human organ transplant procedures listed below. These benefits are subject to all other provisions of the Contract.
   - 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 the Contract:
   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 are released early, then we will provide benefits for at least one home care visit if the attending Physician orders it.

We will 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 Care – Benefits are payable as shown in the Schedule of Benefits for the following:

1. Inpatient Services – Medical care 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.
   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 will not pay benefits for daily medical visits by more than one Physician unless the Member has a separate medical condition the attending Physician cannot 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 cannot treat, we will not provide benefits for medical care visits if the Member is hospitalized for Surgery.

2. 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.
   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.
   c. Home and Other Outpatient Visits – Medical care visits and consultations for the examination, diagnosis and treatment of an injury or illness.

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

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.

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 does 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.

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 Covered Services provided or supplies received outside the United States.

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

We treat insulin as a Prescription Drug whether it is injectable or otherwise. Prescription Drugs do not include Medical Supplies (Medical Supplies are paid under the regular Certificate benefits). However, diabetic supplies will be paid as Prescription Drug.

Specific classes of Over-the-Counter Drugs may be covered as Prescription Drugs. If the Certificate includes coverage for specific Over-the-Counter Drugs, it will be shown in the Schedule of Benefits. You must have a valid prescription for these classes of Over-the-Counter Drugs.

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 Manager (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 does not change when we receive any financial credit. Copayments are flat amounts and likewise do not change when we receive drug manufacturer or PBM credits.

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

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 Certificate does not provide benefits at a non-Contracting Pharmacy.

You must pay the Contracting Pharmacy:
1. 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
2. Any type of service charge including the administration or injection of a Prescription Drug; or
3. 100 percent of the cost of a Prescription order when you fail to show your identification card.

Preventive Screenings – Benefits will be provided, as shown in the Schedule of Benefits 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.

Prosthetic and Orthotic Devices – Benefits are payable for Prosthetic and Orthotic 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.

Rehabilitation – Benefits for taking part in a multi-disciplinary, team-structured Rehabilitation program following severe neurological or physical disability are available.

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 of this Certificate, and 2) begin within 14 days after being discharged from a Hospital following an authorized hospitalization. The Benefit Period Maximum is shown in 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 shall not exceed the quantity and benefit maximum, if any, as shown in your Schedule of Benefits. You can get a list of Specialty Drugs by contacting the Claims Service Center or you can get the list from our Website at www.SouthCarolinaBlues.com. Preauthorization is required for benefits to be available.

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 does not change when we receive any financial credit. Copayments are flat amounts and likewise do not change when we receive drug manufacturer or PBM credits.

Surgery Benefits – Benefits for Surgery include payment for pre- and post-operative care.

1. Reconstructive Surgery – to restore bodily function or correct deformity resulting from disease, trauma, congenital anomalies or developmental anomalies. For the purposes of this Certificate, 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.

2. 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 percent 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 percent of the Allowable Charge is covered for the removal of the second largest lesion and 25 percent 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 procedure. 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.

3. Anesthesia – Anesthesia ordered by the attending Physician and administered by a Physician other than the surgeon or assistant at Surgery.

Therapy Services – Therapy services do not include any of the following unless specifically included in your Schedule of Benefits.

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.

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.

Optional Covered Service

The following optional Covered Service is available for an additional premium. The Schedule of Benefits will show if you purchased this options.

Dental Services – If purchased, we will provide benefits for the following dental services, as shown in the Schedule of Benefits.

Dental services are divided into three classes: Class I, Class II and Class III.

Benefits for covered dental services are payable as shown in the Schedule of Benefits. Classes II and III are subject to the Dental Services Deductible. The Benefit Period Maximum is for all Classes combined and is indicated in the Schedule of Benefits.

Dental services benefits are payable to one dentist or oral surgeon. If the Member transfers from the care of one dentist or oral surgeon to the care of another for the same course of treatment, or if more than one dentist or oral surgeon performs services for the same procedure, benefits are payable as if only one dentist or oral surgeon performed the treatment or procedure.

Dental services related to an Accidental Injury are covered under the Dental Services to Sound Natural Teeth benefit of this Certificate.

1. Class I — Diagnostic and Preventive Services
   a. Dental examinations and diagnosis once each Benefit Period.
   b. Full mouth X-rays once every five years. The five-year period begins on the date the Member has full mouth X-rays after coverage becomes effective.
   c. Supplementary bitewing X-rays once every three years. The three-year period begins on the date the Member has supplementary bitewing X-rays after this coverage becomes effective.
   d. Cleaning, scaling, and polishing of teeth once each Benefit Period.
   e. One fluoride treatment each Benefit Period if the Member is under age 19.
   f. Emergency palliative treatment for pain relief.
   g. Space maintainers for prematurely lost deciduous (baby) teeth if the Member is under age 19.
   h. Diagnostic casts not made in conjunction with any type of prosthodontics.
   i. Pulp vitality tests.
   j. Sealant on permanent teeth that have not had any fillings for children ages 6 -15.

2. Class II — Basic Dental Services and Oral Surgery
    a. Fillings consisting of amalgam and tooth-colored synthetic materials.
    b. Simple extractions.
    c. Oral Surgery (does not include removal of impacted teeth).
    d. Medically Necessary general anesthesia administration during oral Surgery.
    e. Medical Necessary services of an assistant surgeon during covered dental Surgery.
    f. Management of acute infections and oral lesions.

3. Class III — Prosthodontic, Periodontic and Endodontic Services
    a. Inlays that are not part of a bridge.
    b. Crowns that are not part of a bridge.
    c. Onlays that are not part of a bridge.
    d. Removable dentures (complete and partial) and bridges (fixed and removable) every five years, except those needed because of loss or theft. The five-year period begins on the date the Member gets dentures or bridges after this coverage becomes effective.
    e. Fixed bridge and removable denture repair.
    f. Relining or rebasing of removable dentures every six months after initial placement, then once every three years thereafter.
    g. Pulp capping and root canal treatment.
    h. Hemisection.
    i. Apicoectomy (amputation of the apex of a tooth root).
    j. Surgical periodontic examination.
    k. Gingival curettage.
    l. Gingivectomy and gingivoplasty.
    m. Osseous Surgery including flap entry and closure.
    n. Mucogingivoplastic Surgery.
    o. Periodontal cleanings once every three months after the initial periodontic treatment is documented.

See the *Exclusions and Limitations* section of this Certificate for Exclusions and Limitations applicable to Dental Services.

Out-of-Area Services

Out-of-Area Services

Blue Cross and Blue Shield of South Carolina has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain health care services outside of Blue Cross and Blue Shield of South Carolina's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside our service area, you will obtain care from health care Providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from nonparticipating health care Providers. Our payment practices in both instances are described below.

1. **BlueCard Program**

    Under the BlueCard Program, when you access covered health care services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care Providers.

    Whenever you access covered health care services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered health care services is calculated based on the lower of:
    - The billed covered charges for your Covered Services; or
    - The negotiated price that the Host Blue makes available to us.

    Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

    Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

    Laws in a small number of states may require the Host Blue 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 applicable law.

2. **Non-Participating Health Care Providers Outside Our Service Area**

   a. Member Liability Calculation

      When covered health care services are provided outside of our service area by non-participating health care Providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating health care Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating health care Provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

   b. Exceptions

      In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the health care services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating health care Providers. In these situations, you may be liable for the difference between the amount that the non-participating health care Provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

Coordination of Benefits

All of the Benefits provided under this Certificate are subject to this section.

Definitions

1. Plan – Any program providing benefits for services or treatment, and for which those benefits are provided by: 1) group insurance and group subscriber coverage; 2) uninsured arrangements of group coverage; 3) group coverage through HMO's and other prepayment coverage, group practice and individual practice plans; 4) medical benefits coverage in group and individual "no fault" and traditional automobile "fault" type contracts; and 5) group hospital indemnity benefits payments in excess of $100 per day.

   For purposes of this section, the term "Plan" will also include Medicare Part B when a Member Certificate is secondary to Medicare as mandated by federal law, and the person covered under this Certificate did not elect coverage under Medicare Part B.

   The term "Plan" will be construed separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract or other arrangement which reserves the right to coordinate benefits or services of other Plans in determining its benefits and that portion which does not.

2. Covered Services – Any necessary, reasonable and/or customary service or supply specified in this Certificate for which benefits will be provided when provided by a Provider. Payment under this Certificate cannot exceed the amount that would normally be paid in the absence of this section. Personal comfort items provided at the patient's request, such as television, air conditioning and telephone that are listed separately on the Hospital's or Skilled Nursing Facility's regular statement of charges, are not considered Covered Services. If benefits are reduced under a primary plan because the covered person did not comply with the Plan's provisions, such as Second Surgical Opinions, precertification of admissions or services, and preferred Provider arrangements, the amount of the reduction will not be covered for benefits under this Certificate. When the Plan provides benefits in the form of services, the reasonable cash value of each service provided will be considered a paid benefit.

Effects on Benefits

1. If you are also covered for comparable benefits or services under another Plan that should pay first, benefits payable under this Plan will be reduced so that, for Covered Services incurred, benefits available under all Plans will not exceed the total Allowable Charge of such Covered Services. You will receive a notice stating a claim has been denied or that we need information to complete processing the claim. For the files to be updated, you must return the notice with the requested information.

2. The rules establishing the order of benefits determinations are as follows:
   a. The benefits of a Plan that does not contain a Coordination of Benefits provision or other provisions of similar intent will be determined before the Benefits under the Certificate.

   b. The benefits of a Plan which covers a named insured primarily, will be determined before the benefits of a Plan which covers such persons as a Dependent, or secondarily.

   c. When the prior rules do not establish an order of benefit determination, the benefits of a Plan that has covered the person for the longer period of time will be determined before the benefits of a Plan that has covered the person for the shorter period of time.

   d. If a Plan contains order of benefit determination rules that declare that Plan to be excess to or always secondary to all other Plans, this Certificate will coordinate benefits as follows:
      1. If this Certificate is primary, it will pay or provide benefits on a primary basis;

      2. If this Certificate is secondary, it will pay or provide Benefits first, but the amount of benefits payable will be determined as if this Certificate were the secondary Plan. The liability of this Certificate will be limited to such payment;

3. If the other Plan does not furnish the information needed by this Certificate to determine Benefits within a reasonable time after such information is requested, this Certificate will assume that the benefits of the other Plan are the same as those provided under this Certificate and will pay benefits accordingly. When information becomes available as to the actual benefits of the other Plan, any Benefit payment made under this Certificate will be adjusted accordingly;

4. If the other Plan reduces its benefits so that the covered person receives less in benefits than he or she would have received had this Certificate paid or provided benefits as the secondary Plan and the other Plan paid or provided its benefits as the primary Plan and the governing State law allows the right of subrogation, then this Certificate will advance an amount equal to such difference to or on your behalf.

   In no event will this Certificate advance more than it would have paid as the primary Plan less any amount it previously paid. In consideration of such advance, this Certificate will be subrogated to all your rights against the other Plan. Such advance under this Certificate will also be without prejudice to any claim it may have against the other Plan in the absence of such subrogation.

3. If this Certificate is secondary to Medicare as mandated by Federal law, and if the person did not elect coverage under Medicare Part B, Benefits under this Certificate may be reduced by the amount that would have been paid by Medicare Part B had the person elected such coverage.

Right to Receive and Release Necessary Information
For the purpose of determining the applicability of and implementing the terms of this section or any provision of similar purpose of any other Plan, we may, without the authorization of or prior notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which it deems to be necessary for such purposes. Any person claiming benefits under this Plan will furnish such information to us as may be necessary to implement this section.

Facility of Payment
Whenever payments which should have been made under this Plan according to this section have been made under any other Plan, we will have the right to pay over to any organization making such other payments any amounts it determines to be warranted in order to satisfy the intent of this section, and amounts paid will be considered paid benefits under this Plan and, to the extent of such payments for Covered Services, we will be fully discharged from liability under this Certificate.

Right of Recovery
If the amount of the payments we made is more than it should have paid under this COB provision, it may receive the excess from one or more of the following: the Member it has paid or for who it has paid, the other Plan, or other person or organization.

You, or in the case of a minor, the Certificateholder, will, upon request, execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to us or any other Plan.

Subrogation

If you receive medical benefits under this Certificate for an injury caused by the act or omissions of a liable third party and receives 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 not more than the amount that we have paid relating to the injury. This agreement is a condition to receiving benefits under this Certificate. 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 the place of you 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 its 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 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.

Each time a claim is filed with a diagnosis that could be related to an accident or injury, you may receive a notice stating that we need information to complete processing the claim along with a questionnaire regarding the claim. For your files to be updated, you must return the questionnaire with the requested information.

Temporary Exclusion Period

Beginning with the effective date of your coverage under the contract, there are some temporary exclusion periods. During this period no coverage is provided for services, supplies or treatment, including surgery for the condition or disease. These temporary exclusion periods will not apply in case of emergency. The temporary exclusion periods are:

- Six months for acne treatment
- Six months for disorders of the adenoids
- Six months for allergies and allergy testing
- Six months for gastrointestinal reflux surgery
- Six months for hemorrhoids
- Six months for hernia (all types)
- Six months for disorders of the reproductive system
- Six months for disorders of the sinuses
- Six months for strabismus
- Six months for disorders of the tonsils
- Six months for otitis media

Pre-existing Condition Limitations

Pre-existing Conditions are physical or mental conditions (regardless of the cause) for which medical advice, diagnosis, care or treatment was received or recommended within the 12-month period ending on your Effective Date.

Any services, supplies or Prescription Drugs for Pre-existing Conditions are not covered under the Certificate when the treatment relates to a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12-month period prior to the Effective Date.

The Pre-existing Condition Exclusion period ends on the earlier of: 1) the date in which the Member has not received medical care, treatment or supplies for the Pre-existing Condition for 12 months and that period of 12 months ends on or after the Effective Date of coverage, or 2) 12 months after the Effective Date.

The Pre-existing Condition Exclusion will not apply to a Member who obtained coverage prior to age 19.

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 Certificate, we may rescind the Certificate or issue an Endorsement to limit or exclude coverage had we known the true and correct facts at the time the Certificate was issued subject to the *Incontestability* provision of the Master Policy.

Credit for Prior Coverage
Credit for Prior Coverage, which is calculated on a day-by-day basis, can reduce or eliminate the Pre-existing Condition Exclusion unless the condition is excluded by Endorsement.

A period of prior coverage does not count if there is at least a 31-day period where you were not covered under any Health Insurance Coverage. Your Waiting Period for Health Insurance Coverage is not counted toward or against the 31-day period.

Credit for Prior Coverage will be determined when you provide us with a Certificate or other acceptable evidence that shows you had prior Health Insurance Coverage. You have the right to request a Certificate of Creditable Coverage from any prior plan or issuer. If necessary, Blue Cross will request the certificate with your written authorization.

We will notify you of any Pre-existing Condition Limitations period and the basis for the determination. You have the right to submit additional evidence showing you have Credit for Prior Coverage; Blue Cross will then calculate your revised Pre-Existing Limitation Period. We have the right to reconsider our decision if we determine you did not have the full credit for the prior coverage you say you did.

Exclusions and Limitations

Except as specifically provided in this Certificate, even if Medically Necessary, no benefits will be provided for:

- Room and board charges in a Hospital or Skilled Nursing Facility when required Preadmission Review, Emergency Admission Review and/or Continued Stay Review is not obtained. Please refer to the *Preauthorization and Approval* section of this Certificate.
- Hospice Care services or supplies while you are in a Hospital or Skilled Nursing Facility.
- Services and supplies that are not Medically Necessary or not specifically listed in *Covered Services*.
- Services and supplies you received before you had coverage under this Certificate or after you no longer have this coverage except as described in Extension of Benefits under the *Eligibility, Coverage and When Your Coverage Ends* section of this Certificate.

- Services or supplies for which you are entitled to benefits under Medicare or other governmental programs (except Medicaid).
- Injuries or diseases paid by Workers' Compensation or settlement of a Workers' Compensation claim. 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.
- Treatment provided in a government Hospital that you are not legally responsible for.
- Treatment or tests you receive as an Inpatient that could have been done safely as an Outpatient.
- Rest cures; long-term, residential care for the treatment of Mental Health Services or Substance Abuse care; and Custodial Care or domiciliary care (care meant simply to help those who can't care for themselves, such as, but not limited to, help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diet and supervision of medications which can usually be self-administered and which does not require continuous attention of trained medical personnel).
- All admissions to Hospitals or freestanding Rehabilitation Facilities for physical Rehabilitation when you do not receive the required Preauthorization.
- Normal pregnancy or childbirth.
- Illness contracted or injury sustained as the result of: war or act of war (whether declared or undeclared); participation in a riot or uprising; service in the armed forces or an auxiliary unit.
- Any loss that results from you committing, or attempting to commit a felony, or from a Member engaging in an illegal occupation.
- Treatment, services or supplies received as a result of suicide, attempted suicide or intentionally self-inflicted injuries unless it results from a medical (physical or mental) condition.
- Any loss resulting from you 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.
- Investigational or Experimental Services, as determined by us, including but 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;
  - Dorsal Rhizotomy (cutting the back of spinal nerve roots) in the treatment of spasticity (increased tone or tension in a muscle such as a leg);
  - Procedures that involve the transplantation of fetal tissues into a living recipient.
- Services and supplies related to transplants involving mechanical or animal organs, human organ and/or tissue transplant procedures when you do not get the required prior Approval and it is not done at a Designated Provider, or unless specifically listed in *Covered Services*.
- 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, also known as Cosmetic Surgery. 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. Cosmetic Surgery does not include reconstructive Surgery incidental to or following Surgery resulting from trauma, infection or other diseases of the involved part.
- Reduction mammoplasty for macromastia unless you are within 20 percent of the ideal body weight.
- Any treatment or Surgery for obesity (even if morbid obesity is present), weight reduction, weight control such as gastric by-pass, insertion of stomach (gastric) banding, intestinal bypass, wiring mouth shut, liposuction or complications from it. This includes any reversal or reconstructive procedures from such treatments.
- Eyeglasses; contact lenses (except after cataract Surgery) and hearing aids and exams for the prescription or fitting of them. Any Hospital or Physician charges related to refractive care such as radial keratotomy (Surgery to correct nearsightedness), keratomileusis (laser eye Surgery or LASIK), lamellar keratoplasty (corneal grafting) or any such procedures that are designed to alter the refractive properties of the cornea.
- Home Health Care and Hospice Care, except as provided in *Covered Services* and with a Preauthorization when shown in your Schedule of Benefits.

- 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; medical social services, occupational, visual or speech therapy; recreational, education or play therapy; biofeedback or psychological testing to determine if a learning disability or behavior disorder exists; therapy for learning disability or behavior disorder exists; therapy for learning disabilities and communication delay; perceptual disorders; behavioral disorders; mental retardation or vocational rehabilitation.
- Animal Assisted Therapy, rTMS, Eye Movement Desensitization and Reprocessing (EMDR), behavioral therapy for solitary maladaptive habits or Rapid Opiate Detoxification.
- Routine physical exams, except as shown in your Schedule of Benefits.
- Services, care or supplies used to detect and correct, by manual or mechanical means, structural imbalance, distortion or subluxation in your body for the 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.
- Any services or supplies for the diagnosis or treatment of infertility. This includes, but is not limited to: fertility drugs, lab and X-ray tests, reversals of sterilization, surrogate parenting, artificial insemination and in-vitro fertilization. Sterilization is also excluded.
- Any services or supplies for the diagnosis or treatment of sexual dysfunction. This includes, but is not limited to: drugs, lab and X-ray tests, counseling, transsexual procedures or penile prostheses necessary due to any medical condition or organic disease. If benefits are available for Durable Medical Equipment, a penile prosthesis will be considered for payment only after Medically Necessary prostate Surgery.
- Charges for acupuncture, hypnotism and TENS unit, or services for chronic pain management programs. This includes any program developed by centers with multidisciplinary staffs intended to provided the interventions needed to allow the patient to develop pain coping skills and freedom from analgesic medications dependence.
- Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. This exclusion does not include corrective Surgery, treatment due to diabetes or treatment for metabolic or peripheral vascular disease.
- Any services, supplies or treatment for excessive sweating.
- Orthomolecular therapy including infant formula, nutrients, vitamins and food supplements, even if the Physician orders or prescribes them. Enteral feedings when not a sole source of nutrition.
- Physician charges for telephone consultations, blood and blood products, or separate charges for services provided by employees of Hospitals, laboratories or other institutions.
- Any service or supply related to dysfunctional conditions of the chewing muscles, wrong position or deformities of the jaw bone(s), orthognathic deformities or temporomandibular joint syndrome (headache, facial pain and jaw tenderness caused by jaw problems usually known as TMJ. This exclusion, however, will not apply to Medically Necessary surgical correction of disorders of TMJ. As used in this exclusion, Medically Necessary surgical correction of TMJ means: surgical correction of skeletal malrelationships or deformities of the jaws that cause documented chronic, persistent pain or debilitating loss of function and have required treatment or medication. The presence of a documented congenital anomaly alone does not establish Medical Necessity. Preauthorization is required.
- Dental care or treatment, except as provided when the Optional Dental Services coverage is purchased, as follows. Your Schedule of Benefits will show if you have purchased the Optional Dental Services coverage. However, the following are never covered:
  - Orthodontic treatment, services and supplies except orthodontics necessary for care and treatment of cleft lip and palate.
  - Services or supplies related to teeth that were missing before the Effective Date of the Certificate.
  - Implants or bridges involving implants.
  - Appliances or restoration to increase vertical dimension or restore an occlusion.
  - Services or supplies for cosmetic or aesthetic purposes including personalized or characterization of dentures.
  - Replacement of a denture that could have been repaired or extended.
  - Treatment after you are no longer covered even if treatment began before this coverage was cancelled. Benefits are payable for dentures ordered and fitted while coverage was still in effect if the dentures are delivered within 31 days of the cancellation date. Benefits may also be payable for completion of dental services that are part of a treatment plan approved by us before the cancellation date if the services are completed within 30 days of the date the treatment plan was approved.
  - Treatment that is more expensive than necessary. If you or your dentist or oral surgeon chooses a course of treatment that is more expensive than that of other Providers, benefits are payable for the less costly procedure if it is consistent with accepted standards of dental practice.
  - Charges for missed appointments or for non-dental services, such as completion of claim forms, reports or booklets.
  - Charges for visits at home or in the Hospital, except in connection with emergency care.
  - Services submitted after the time limit for filing claims has expired.
  - Removal of impacted teeth.

- The following Prescription and/or Specialty Drugs:
  - When used for or related to weight control, obesity, cosmetic purposes (such as Tretinoin or Retin-A), hair growth, hair removal and smoking cessation unless shown in your Schedule of Benefits. Also excludes all vitamins and injectable drugs other than insulin.
  - More than the number of days supply allowed as shown in your Schedule of Benefits.
  - Refills in excess of the number specified on your Physician's Prescription Order or refills dispensed more than one year after the original prescription date.
  - More than the recommended daily dosage as described in the current *Physician's Desk Reference* or as recommended under the guidelines of our Pharmacy Benefit Manager, whichever is lower.
  - When administered or dispensed in a Physician's office, Skilled Nursing Facility, Hospital or any other place that is not licensed to dispense drugs.
  - When there is an Over-the-Counter (OTC) Drug equal to it except for OTC Drugs considered to be Prescription Drugs, if shown in the Schedule of Benefits. Any OTC supplies, devices or supplements.
  - When not consistent with the diagnosis and treatment of an illness, injury or condition or that is excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care.
  - When you do not receive Preauthorization. Please contact the Claims Service Center at the phone number listed in the *How to Contact Us if You Have a Question* section to see if a specific drug requires Preauthorization.
  - When used for or related to non-covered services or conditions.
  - 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 excluded unless growth hormone deficiency is documented.
  - That require step therapy when step therapy is not done. Step therapy is when you are required to try certain drugs to treat a medical condition before we will cover another drug for that condition.
- Devices of any type, even if given through a prescription, such as but not limited to: therapeutic devices, artificial appliances or similar devices.
- Charges incurred as the result of virtual office visits including Prescription Drugs. A virtual office visit occurs when you are not physically seen or physically examined by the Physician.
- Luxury or convenience items and travel expenses, whether or not a Physician recommends or prescribes them.
- Transportation, except as shown in *Covered Services*.
- Durable Medical Equipment when you do not get the required Preauthorization when the cost is more than the amount shown in your Schedule of Benefits.
- Benefits will be denied or reduced for procedures or services as shown in your Schedule of Benefits when you do not get the required prior Approval.
- Any type of fee or charge for handling medical records, filing a claim or missing a scheduled appointment.
- For services or supplies performed or furnished by a member of your immediate family. A member of your family means spouse, parents, grandparents, brothers, sisters, aunts, uncles, children or in-laws.
- Any service, supply or treatment for complications resulting from any non-covered procedure or condition.
- Services or supplies not needed for diagnosis or treatment of an illness or injury, for which you are not legally responsible for paying or for which a charge is normally not made in the absence of insurance.
- Pulmonary rehabilitation, except in conjunction with a covered lung transplant.
- Adjustable cranial orthosis (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling surgery.
- Services, supplies or treatment for varicose veins, including but not limited to, endovenous ablation, vein stripping or sclerosing solutions injection.
- Charges for services or supplies from an independent health care professional whose services are normally included in Facility charges.
- Pre-conception testing, pre-conception counseling or pre-conception genetic testing.

Certificate of Creditable Coverage

Blue Cross will provide you a Certificate of Creditable Coverage at the time coverage stops. If you need a copy of the certificate at a later time, you must request the Certificate of Creditable Coverage within 24 months at the end of coverage. You may also request a Certificate of Creditable Coverage from us even if your coverage is still in force. To request a Certificate of Creditable Coverage, please write or call our Claims Service Center at the address or phone number listed in the *How to Contact Us if You Have a Question* section.

Appeals/Grievance Procedures

Please direct any complaints or disagreements you have regarding claims for services or benefits to us at 803-264-3475 from Columbia, or 800-868-2500, ext. 43475 from anywhere else. You can also send us a secure email through the Ask Customer Service feature of My Health Toolkit on our website at www.SouthCarolinaBlues.com.

A Preauthorization and Approval denial will be considered a denied claim for purposes of this provision. You can direct any complaints or disagreements you have regarding a Preauthorization and Approval to us at 803-736-5990 from Columbia, or 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
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 us to provide a determination for each of these claims are listed below:

1. 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 we determine that for reasons beyond our control, an extension is necessary. If an extension is required, we will notify you within the initial 15-day time period that an extension is necessary.

   If we receive incomplete information from you and additional information is required to make a determination, you will be notified within five calendar days. You have 60 calendar days to provide the required information. If we do not receive the required information within the 60-day time period, the claim may be denied.

   When we require an extension due to incomplete information, we are entitled to the rest of the initial determination period to reach a benefit determination after the additional information is received from you or the Provider.

2. Urgent Care Claim – A determination, based on Medical Necessity, must be provided to you in writing or in electronic form within 72 hours of the original Urgent Care Claim. We will defer to the attending Provider with respect to the decision as to whether a claim constitutes "urgent care." A Provider may be considered an authorized representative without a specific designation by you when the Approval request is for Urgent Care Claims (medical conditions which require immediate treatment).

   We will notify you or your 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 we do not receive complete information in which to make a Medical Necessity decision. If we do not receive the required information from you within 48 hours after notifying you, the claim may be denied.

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

   An extension of 15 calendar days may be provided if we determine that for reasons beyond our control, an extension is necessary. If an extension is required, we will notify you within the initial 30-day time period that an extension is necessary.

   If we receive incomplete information from you and additional information is required to make a determination, you will be notified within 30 calendar days. You have 60 calendar days to provide the required information. If we do not receive the required information within the 60-day time period, the claim may be denied.

   When we require an extension due to incomplete information, we are entitled to the rest of the initial determination period to reach a benefit determination after the additional information is received from you or the Provider.

4. Concurrent Care Decision – If we make a decision to reduce or stop benefits for Concurrent Care that had previously been approved, you must be notified sufficiently in advance of the reduction or termination of benefits to allow you time to appeal the decision before the benefits are reduced or terminated.

   If you request 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. We must make a decision within 24 hours.

How to File an Appeal
If you wish to file a formal **appeal**, you must write to Blue Cross and Blue Shield of South Carolina, Member Services 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 Policy 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:

1. Pre-service Claim – You have 180 days to appeal our decision on a Pre-service Claim or a Concurrent Care decision. We must complete the appeal process within 15 calendar days after receiving the appeal. If you still do not agree with the Company's decision, you can file a second appeal within 90 days after receiving the Company's decision on the first decision. The Company must complete the second appeal process within 15 calendar days after receiving the second appeal.
2. Urgent Care Claim – You have 180 days to appeal our decision on an Urgent Care Claim. We must complete the appeal process within 72 hours after receiving the appeal.
3. Post-service Claim – You have 180 days to appeal our decision on a Post-service Claim. We must complete the appeal process within 30 calendar days after receiving the appeal. If the Member still does not agree with the Company's decision, the 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.

You will have the opportunity to present testimony, submit written comments, documents or other information in support of the appeal and you will have access to all documents that are relevant to the claim. If we consider or present additional evidence in connection with the appeal or use new or additional reasons as the basis of the adverse determination, you will be notified of the new evidence or rationale in advance of the date of the appeal decision. The appeal will be conducted by someone other than the person who made the initial decision. No deference will be afforded to the initial determination.

You will be considered to have exhausted the internal appeal process if we fail to strictly adhere to the internal appeal process, unless the violation was:
1. De minimis;
2. Non-prejudicial;
3. Attributable to good cause or matters beyond the Company's control;
4. In the context of an ongoing good-faith exchange of information; and
5. Not reflective of a pattern or practice of non-compliance.

You may write to us and request an explanation of our basis for stating we meet the above standard.

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 four months 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 can 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
800-768-3467

Standard External Reviews
You can request an external review if we deny your claim, either in whole or in part. You may be held financially responsible for the covered benefits. You can only request an external review after you have completed the grievance and appeal process above. You can 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 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 five business days of your request for an external review, we will respond by either notifying the South Carolina Department of Insurance of a request for external review and requesting the South Carolina Department of Insurance to assign the 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.

You have five business days from the date you receive the Company's response to submit additional information to the IRO in writing. The IRO must consider this additional information when conducting its review. The IRO will also forward this information to the Company within one business day of its receipt.

If your request is assigned to an IRO, the IRO will determine within five 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 seven 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.

If the IRO's decision is to allow benefits, within five 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 Reviews
You can 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. You can also request an expedited external review 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. You can request an expedited external review at the same time as requesting an expedited internal review.

When we receive your request for an expedited external review, the South Carolina Department of Insurance will assign your review to an IRO and we will forward our 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.

The IRO must make its decision as fast as possible but within no more than 72 hours after it receives the request for expedited review. 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.

If your Physician certifies that you have a "serious medical condition," you are entitled to an expedited external review. A serious medical condition, as used in this provision, means one that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place your health in serious jeopardy or jeopardize your ability to regain maximum function.

AMENDMENT TO THE PERSONAL BLUE[SM] POLICY

(Policy form numbers listed below)

Women's Health Care Member Certificate Insert

(The following additions/revisions should not be construed as a complete replacement of the sections in your Member Certificate unless otherwise noted.)

This supplement to your Member Certificate is effective on or after August 1, 2012.

Covered Services is revised by the addition of:

Breastfeeding Equipment – Benefits are payable for breastfeeding equipment as indicated on the Schedule of Benefits.

Exclusion and Limitations is modified by the revision of the following exclusions. The revisions should not be construed as a complete replacement of the section.

- Any services or supplies for the diagnosis or treatment of infertility. This includes, but is not limited to: fertility drugs, lab and X-ray tests, reversals of sterilization, surrogate parenting, artificial insemination and in-vitro fertilization. Male Sterilization is also excluded.

- Pre-conception testing or pre-conception genetic testing.

Out-of-Area Services, the first paragraph is deleted in its entirety and the following substituted:

Blue Cross and Blue Shield of South Carolina has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain health care services outside of Blue Cross and Blue Shield of South Carolina's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program.

The following Optional Family Coverage Endorsement must have been selected on your Application and coverage approved to be included with your Certificate.

BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA

(An Independent Licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.)

www.SouthCarolinaBlues.com

Optional Family Coverage Member Certificate Endorsement

The Certificate to which this Endorsement is attached is amended to add coverage for Dependents.

If you chose the Optional Family Coverage Endorsement, it will be shown in your Application, which is a part of your Certificate.

(The following additions/revisions should not be construed as a complete replacement of the sections in your Member Certificate unless otherwise noted.)

This supplement to your Member Certificate is effective on your Member Certificate Effective Date. The Effective Date of your Member Certificate is the date shown in the Schedule of Benefits after this Optional Endorsement is selected.

For purposes of this Endorsement, the following Definitions are added to the Certificate:

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

Coverage for Dependents is subject to the following:

Eligibility, Coverage and When Your Coverage Ends

Coverage is available to Dependents of the Certificateholder. If coverage ends for the Certificateholder, coverage for the Dependents will also end, unless coverage is extended as described in this Endorsement. Coverage may also be extended for currently covered Dependents if the Certificateholder dies or becomes eligible for Medicare. If coverage ends for the Certificateholder due to death or Medicare eligibility, the spouse, if covered under the same Certificate, would become the Certificateholder. If the spouse is not covered, each covered Dependent child will be issued his or her own Certificate. Death or Medicare eligibility of the Certificateholder is the only time a Dependent child under the age of 19 is eligible for a Certificate without family coverage.

All provisions of the Certificate apply to Dependents as they apply to the Certificateholder.

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 the Certificate 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 coverage being effective on the first or the 15th of month after we receive the application 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. Coverage will be effective on the first or the 15th of month after we receive the application for that Dependent child.

Incapacitated Dependent Child: The limiting age doesn't apply to a 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 Certificateholder or Certificateholder'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 26th birthday. 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 the Certificateholder coverage ends for any reason, except in the case of death or Medicare eligibility, coverage for an Incapacitated Dependent Child will also end.

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 Certificate 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 Certificate lapses due to non-payment of premiums or is non-renewed; or
3 The premium due date following the date he or she reaches age 26.

An Incapacitated child's coverage, however, will not end simply because he or she has reached age 26.

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

Pre-Existing Condition Limitations: The Pre-existing Condition Limitation is not applicable to a dependent who obtains coverage prior to age 19.

Deductible, Out-of-Pocket Maximum and Maximum Benefits

The application of the Deductible and Out-of-pocket Maximum for family coverage is shown in the Schedule of Benefits. Any applicable Benefit Period Maximum will apply to each Member each Benefit Period.

Continuation of Coverage

If the Member has been continuously insured under the Certificate for at least six months and coverage is terminated for any reason other than nonpayment of the required premium, then the Member is entitled to continue coverage under the Certificate through the end of the month the Certificate is cancelled plus an additional six months. The Member is not entitled to have this coverage continued if the Member was entitled under federal law to continuation of his or her coverage for a period of greater than six months.

Continuation of Coverage for Your Former Spouse: If a spouse covered under this Certificate is no longer eligible because of a divorce, then he/she may obtain a similar policy from us without proof of good health, but only if the spouse sends us written notification and the required premium within 60 days after the legal divorce

The new policy will provide coverage from us similar to, but not greater than, this coverage. Credit will be given for any Waiting Periods met under this Certificate. 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 Certificate.

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