Schedule of Benefits for Personal BluePlan℠ 1

Policyholder's Name: Your Name

Policyholder's ID Number: Your Policy ID Number

Date of Birth: Your Date of Birth

Type of Plan: SINGLE or FAMILY

Effective Date: Your Effective Date will be either the 1st or the 15th of the month

Benefit Period: Begins on Your Effective Date of Coverage and continues for 365 (366 for leap year) or January 1 through December 31.

Covered Dependents: Dependent Names, if covered

Benefit Description and Premium Schedule

Form	Benefit Description	Premium
12100M-A	Personal BluePlan 1	
12326M-A	Personal BluePlan 1 with Dental Coverage	
12130M-A	Personal BluePlan 1 Limited Benefits Health Insurance	
12133M-A	Personal BluePlan 1 Limited Benefits Health Insurance with Dental Coverage	Your Premium
	Optional Drug Card	Your Premium or Not Purchased
12081M-A	Optional Accident Medical Expense Endorsement	Your Premium or Not Purchased
12082M-A	Optional Maternity Endorsement	Your Premium or Not Purchased
	Total <u>Monthly</u> Premium	Total Premium

Schedule of Benefits for Personal BluePlan 1

(continued)

Deductible – You Pay	You Choose one of the following: $250 $500 $1,000 $1,500 $2,000 $3,000 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	$35 Primary Care Physician (PCP)* Office Visit $60 Specialist* Office Visit $0 per In-Network Facility Inpatient Admission $250 per Out-of-Network Facility Inpatient Admission *Copayments for Primary Care Physicians and Specialists are In-network only. Copayments do not apply to the Deductibles or the Out-of-Pocket Maximums. Copayments will continue even after you reach your Out-of-Pocket Maximum.
Out-of-Pocket Maximum – You Pay	You Choose 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 Maternity or 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 Member per Benefit Period)	$750,000 for Benefit Periods beginning 9/23/2010 through 9/22/2011; $1,250,000 for Benefit Periods beginning 9/23/2011 through 9/22/2012; $2,000,000 for Benefit Periods beginning 9/23/2012 through 12/31/2013; and Benefits Periods beginning 1/1/2014 there will be no annual dollar limits for essential health benefits. Essential benefits include the following more restrictive limits: 60 days for Skilled Nursing Facility Services 60 visits for Home Health Care 30 visits for Short-Term Physical Therapy Services and Occupational Therapy combined 20 visits for Speech Therapy 25 Outpatient/Physician visits and 7 days Inpatient for Mental Health Services and/or Substance Abuse Care Separate Benefit Period Maximums apply to the following: $50,000 for Prosthetics 6 months per episode for Inpatient and Outpatient Hospice Care

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

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

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

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

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

	WE PAY IN-NETWORK PROVIDERS	**WE PAY OUT-OF-NETWORK PROVIDERS**
Physician Services		
Physician charges for services in an Outpatient Hospital or Clinic, including Surgery, (except Mental Health Services and/or Substance Abuse Care), Outpatient lab and X-ray services and all other miscellaneous services	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)	100% after the Copayment	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
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

Schedule of Benefits for Personal BluePlan 1

(continued)

	WE PAY IN-NETWORK PROVIDERS	WE PAY OUT-OF-NETWORK PROVIDERS
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
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
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

Schedule of Benefits for Personal BluePlan 1

(continued)

	WE PAY IN-NETWORK PROVIDERS	WE PAY OUT-OF-NETWORK PROVIDERS
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

Schedule of Benefits for Personal BluePlan 1

(continued)

Blue Rx℠

	WE PAY PARTICIPATING NETWORK PHARMACY	WE PAY NON-PARTICIPATING NETWORK PHARMACY
Prescription Drugs		
Blue Rx Generic, Preferred and Non-Preferred Drugs	90%, 80%, 70% or 60% per prescription or refill after the Deductible	70%, 60%, 50% or 40% per prescription or refill after the Deductible
Generic Oral Birth Control	100% per prescription or refill	100% per prescription or refill
Preferred and Non-Preferred Oral Birth Control	90%, 80%, 70% or 60% per prescription or refill after the Deductible	70%, 60%, 50% or 40% per prescription or refill after the Deductible
	Benefits are limited to a 90-day supply.	Benefits are limited to a 31-day supply.

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

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

Schedule of Benefits for Personal BluePlan 1

(continued)

Drug Card

	WE PAY PARTICIPATING NETWORK PHARMACY	WE PAY NON-PARTICIAPTING NETWORK PHARMACY
Prescription Drugs		
Drug Card Generic, Preferred and Non-Preferred Drugs	100% per prescription or refill after you pay the Prescription Drug Copayment of: $8 for Generic and designated Over-the-counter Drugs $30 for Preferred Drugs $60 for Non-preferred Drugs	70%, 60%, 50% or 40% per prescription or refill after you pay the Prescription Drug Copayment of: $8 for Generic and designated Over-the-counter Drugs $30 for Preferred Drugs $60 for Non-preferred Drugs
Generic Oral Birth Control	100% per prescription or refill	No Benefits
Preferred and Non-Preferred Oral Birth Control	100% per prescription or refill after 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 with 3 Prescription Drug Copayments.	No Benefits Benefits are limited to a 31-day supply or a 90-day supply with 3 Prescription Drug Copayments.

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

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

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

Dental Services

Dental Services — Purchased or Not Purchased

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 per 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%

Accident Medical Expense

Accident Medical Expense — Purchased or Not Purchased

Covered Service	Percentage of Allowable Charges Payable
Covered Services due to an accident	100% of the first $500

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

Maternity Care

Maternity — Purchased or Not Purchased

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

Period of Time	Percentage of Allowable Charges Payable
Charges incurred during the first 12 months of coverage	0%
Charges incurred during the 13th month through 24th month of coverage	60%
Charges incurred during the 25th month through 36th month of coverage	80%
Charges incurred during or after the 37th month of coverage	100%

PERSONAL BLUEPLAN[SM] 1 WITH DENTAL COVERAGE
MAJOR MEDICAL EXPENSE COVERAGE WITH
LIMITED BENEFITS FOR HUMAN ORGAN
AND/OR TISSUE TRANSPLANTS

Guaranteed Renewable Except for Stated Reasons

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

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

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

Premium Rate Subject to Change

Premiums are based on each attained age group for an individual (including Dependents) covered under this Policy. Current premiums for this Policy are shown on the Schedule Page that is included with the Policy. Premiums will change if you change your place of residence and/or when you or your covered Dependents' attained age changes. Premium rates may also be changed if we take the same action on all policies issued with the same form number as this Policy. In this case, we will notify the Policyholder of the new premium rate at least 31 days before the next due date.

Right to Examine Policy for 30 Days

If you are not satisfied with this Policy, return it to us or our agent within 30 days after it is received. All premiums will then be refunded minus any claims paid. If the Policy is returned, it will be void from the beginning. The parties will be in the same position as if no Policy had been issued.

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA

An Independent Licensee of the Blue Cross and Blue Shield Association
(www.SouthCarolinaBlues.com)

James A. Deyling
President Blue Cross and Blue Shield Division

This Policy contains a requirement for Preauthorization and Approval of certain services, including Mental Health Services and Substance Abuse care. See page 18 for details.

Allowable Charges may be subject to a benefit payment reduction or non-payment if Preauthorization and Approval is not obtained.

Important Notice
Concerning Statements in Your
Application for Insurance

Please read the copy of the application attached to your Policy. Misstatements in the application can cause an otherwise valid claim to be denied. If a Covered Person has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material facts related to insurability, coverage may be rescinded or void. Coverage can also be voided, subject to the Time Limit on Certain Defenses provision. Carefully check the application and, if any information shown on the application is not correct and complete or if any medical history has not been included, write to Blue Cross and Blue Shield of South Carolina, Individual Membership Department, Post Office Box 61153, Columbia, South Carolina, 29260, within 10 days. The application is part of the insurance Policy. The insurance Policy was issued on the basis that the answers to all questions and any other material information shown on the application are correct and complete. No agent or employee of Blue Cross and Blue Shield of South Carolina has the authority to waive any of the requirements within the application or waive any of the provisions within this Policy.

After this Policy has been in force for two years, no statement made in any application (unless fraudulent) will be used to void the Policy or deny any claim beginning after the two-year period according to the Time Limit on Certain Defenses provision.

Table of Contents

A. GENERAL

Introduction

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

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

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

Preauthorization and Approval is needed in advance for certain services in order to receive maximum benefits available under this Personal BluePlan Policy.

How to Contact Us

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

If you have any questions about your Personal BluePlan claims, please contact the Claims Service Center. Telephone numbers, the mailing address and website are listed below. You also can find the mailing address on the back of your Blue Cross identification (ID) card.

Telephone Numbers:
803-264-1000 (from the Columbia area)
800-868-2500, ext. 41000 (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 Address:
www.SouthCarolinaBlues.com, then log into My Health Toolkit®

If you have any questions about your Personal BluePlan eligibility or rates, please contact the Individual Membership Department. Telephone numbers, the mailing address and website are listed below.

Telephone Numbers:
803-264-2757 (from the Columbia area)
800-868-2500, ext. 42757 (from all other areas)

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

Website Address:
www.SouthCarolinaBlues.com, then log into My Health Toolkit

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

For MRIs, CT scans or PET scans in an Outpatient Facility or a Physician's Office, call National Imaging Associates at:
866-500-7664

For Preadmission 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)

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 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 that preauthorizes behavioral health benefits.

Your Fastest Place for Answers – www.SouthCarolinaBlues.com

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

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

- Learn more about our products and services
- Stay informed with all the latest Blue Cross news, including press releases
- Link to other health-related websites
- Use My Health Toolkit
- Locate a network Physician, Hospital or Pharmacy

My Health Toolkit

Go to My Health Toolkit from www.SouthCarolinaBlues.com to:

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

When Your Coverage Begins and Ends

Eligibility: This Personal BluePlan Policy is available to you and your spouse (both must be under age 65 and live in South Carolina) and Dependent children who are under age 26.

For You: Your insurance will become effective at 12:01 a.m. Eastern Standard Time on the Effective Date shown on the Schedule Page.

For Your Dependents: Coverage for a Dependent will become effective at 12:01 a.m. Eastern Standard Time on the Effective Date shown on the Schedule Page.

Adding Your Spouse: You may add your spouse by submitting an application for our approval and paying the additional premium required. We will require proof of your spouse's good health. Your spouse will not be covered until we receive the required premium and give you written notice of our approval.

Adding a Child: If you or your spouse gives birth or adopts a child while this Policy is in force, then the child is covered from the moment of birth or adoption for Medically Necessary Covered Services and supplies. This includes any necessary care and treatment of medically diagnosed birth defects, diseases and anomalies or complications arising from a premature birth. You must provide us with a completed application within 31 days of the birth or adoption along with the appropriate premium payment in order for the coverage to be effective from the moment of birth.

An adopted child will be covered on the same basis as other covered children either: 1) from the moment of birth when a decree of adoption has been entered into by you or you and your spouse within 31 days after the date of the child's birth and you or your spouse has temporary custody; or 2) on the date the adoption proceedings have been completed and a decree of adoption is entered into within one year from the institution of proceedings, unless extended by order of the court by reason of the special needs of the child; or 3) on the Effective Date of this Policy, whichever is later.

A child is considered "adopted" on the date the child is placed in your home for the purpose of adoption. The child is no longer considered "adopted" on the date placement is disrupted prior to legal adoption and the child is removed from placement with you or with you and your spouse.

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

Termination of Your Insurance: Your coverage will end at 12:01 a.m. Eastern Standard Time: 1) on the next premium due date after we receive your request in writing; or 2) on the date the Policy lapses or is non-renewed, whichever occurs first. In the event of your death, your spouse or a Dependent child, if covered under the Policy, will become the Policyholder.

Benefits will be paid to the end of the period for which premiums were accepted.

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

Benefits will be paid to the end of the period for which premiums were accepted.

Termination of Insurance for Your Other Covered Dependents: Coverage will end for a child at 12:01 a.m. Eastern Standard Time on the earlier of:
1. The next premium due date after we receive your request in writing;
2. The date the Policy lapses or is non-renewed; or
3. The premium due date following the date he or she reaches age 26.

Benefits will be paid to the end of the period for which premiums were accepted.

Conversion of Coverage for Your Former Spouse and Non-Incapacitated Dependent Children: If a spouse covered under this Policy is no longer eligible because of a legal divorce, or if a non-incapacitated Dependent child covered under this Policy is no longer eligible because of reaching the age limit, then they may obtain a similar policy from us without proof of good health, if:
1. The spouse sends us written application and the required premium within 60 days after the legal divorce; or
2. The non-incapacitated Dependent child sends us written application and the required premium within 30 days after reaching the age limit.

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

Any exclusion riders on this Policy will be carried forward to the new policy.

We are not required to issue a policy covering a person (other than a divorced spouse) if:
1. He or she is already covered for similar benefits by another hospital, surgical, medical or major medical insurance policy; hospital or medical service group contract; medical practice or other prepayment plan; or any other plan or program.
2. He or she is eligible for similar benefits, whether or not covered by such benefits, under a plan of coverage for persons in a group, whether on an insured or uninsured basis; or
3. Similar benefits are provided or available to him or her through the requirements of a state or federal law.

Extension of Benefits after Termination of Coverage: In the event your Policy is non-renewed, coverage may be extended if you or your covered Dependents are in the Hospital or if you or your Covered Dependents are Totally Disabled when coverage under this Policy ends.

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

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

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

Incapacitated Dependent Child: The limiting age does not apply to a Dependent child who is: 1) incapable of self-sustaining employment because of mental or physical handicap; and 2) chiefly dependent upon the Policyholder or Policyholder's spouse for support and maintenance. The handicap must have developed before the child reached the age at which coverage would otherwise terminate. To keep coverage for an incapacitated child (so long as this Policy is still in force), Blue Cross and Blue Shield of South Carolina must receive written proof of the incapacity and dependency from a medical doctor (M.D.) no later than 31 days after the child has reached the age at which the coverage otherwise terminates. If we decide that the child is incapacitated based on the medical doctor's documentation, written documentation must be sent to us every year, within 31 days of the child's birthday after a two-year period when the child reached the age limit. If your coverage ends for any reason, coverage for an incapacitated Dependent Child will also end.

Cancellation: You may cancel this Policy at any time by written notice delivered or mailed to us. The cancellation will be effective on the next premium due date after we receive your request in writing.

Deductible, Out-of-pocket Expense Limit and Maximum Benefits

Maximum Deductible per Covered Person: Once the total sum of Allowable Charges equals the maximum Deductible, except for covered Special Dental Services, no additional amounts will be applied toward the Deductible during that Benefit Period unless you choose to increase the Deductible.

Under the Policy you may choose the Deductible. The Deductible you chose is shown on the Schedule Page and on your application.

Special Dental Services Deductible: This Policy provides benefits for covered Special Dental Services after the Special Dental Services Deductible is met. This Special Dental Services Deductible applies to covered Class II and Class III Special Dental Services as provided in *Special Dental Services* section of this Policy. The Special Dental Services Deductible is not optional. Once the total sum of Allowable Charges for Special Dental Services equals the Special Dental Service Deductible, no additional amounts will be applied toward the Special Dental Services Deductible during the Benefit Period.

The Special Dental Services Deductible is shown on the Schedule Page.

Applying the Deductible per Covered Person: Only one Deductible per Covered Person and only one Special Dental Services Deductible per Covered Person will be applied in a Benefit Period.

Changes in the Deductible: You may apply for an increase or decrease in the Deductible, except for covered Special Dental Services, under this Policy. You may do this:
1. At the beginning of a new Benefit Period; or
2. Within 30 days before or 90 days after the effective date of a premium change and no claims have been incurred during that Benefit Period.

You must request the change in writing. The change must be one we offer at that time. The new premium will be based on:
1. Your sex and current age;
2. The rates in effect; and
3. The rates in use where you live at the time.

The change will go into effect on the next premium due date after we approve the change. For decreases in the Deductible, these additional rules apply:
1. Proof of good health, satisfactory to us, must be furnished.
2. Any decrease 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 effective date of the change.

Out-of-pocket Expense Limit per Covered Person: A specified dollar amount of Coinsurance incurred and payable by a Covered Person for Covered Services in a Benefit Period. It does not include any Deductibles or Copayments; the Special Dental Services Deductible, Coinsurance amounts for Mental Health Services and/or Substance Abuse care, Coinsurance amounts for Special Dental Services, Coinsurance amounts for Prescription Drugs, when shown on the Schedule Page; 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 Policy.

The Rate of Payment will be increased to 100 percent of the Allowable Charges when a Covered Person reaches his or her Out-of-pocket Expense Limit. However, the Rate of Payment **will not be** increased to 100 percent for Mental Health Services and/or Substance Abuse care or Special Dental Services.

Under this Policy you choose the Out-of-pocket Expense Limit. The Out-of-pocket Expense Limit you chose is shown on the Schedule Page and on your application.

Benefit Period Maximum: The Benefit Period Maximum is the maximum amount for Covered Services that we will pay per Covered Person per Benefit Period. The Benefit Period Maximum is shown on the Schedule Page.

How to File Claims

If you receive health care services or supplies from a Preferred Blue® Provider, the Provider will file your claims for you.

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

1. **Comprehensive Benefits Claim Form for each different patient.** 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:
   - Provider's name and address
   - Patient's name and date of birth
   - Policyholder's Blue Cross ID number
   - Description and cost of each service
   - Date that each service took place
   - Description of the illness or injury (diagnosis)

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

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

How to File a Claim for Prescription Drugs: To file your claim for Prescription Drugs:

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

How to File Special Dental Services Claims: Special Dental Services claims should be filed on a Dental Claim Form. These forms are available from our Claims Service Center and many dentists' offices. Many Providers will fill out the claim forms or file the claims for you. If you must file your own claim, attach the itemized bill(s) to a Dental Claim Form. Special Dental Services claims should be sent to: Dental Claims Unit, Blue Cross and Blue Shield of South Carolina, Post Office Box 100300, Columbia, SC 29202.

How Long You Have to File a Claim: We must receive your claim, Provider's bill and/or receipt by the end of the year following the year you received the services or supplies. So, if you saw a Physician on March 1, 2001, you have until December 31, 2002, to submit your complete claim. Exception is made in the absence of legal capacity.

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 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.

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.

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.

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.

All requests for external review will be at our expense.

B. DEFINITIONS

Allowable Charge: The actual charge as 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 actual charges made for similar services, supplies or equipment by Providers and filed with us during the past calendar year;
2. The Maximum Payment for the past 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 generally should not vary significantly in quality from one Provider to another;
4. A set of allowances that has been mutually agreed upon by Contracting Providers and Blue Cross; or
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 above, we may, through our medical staff and/or consultants, determine the Maximum Payment based on comparable or similar services or procedures.

Ambulatory Surgical Center: A Facility that is licensed for Outpatient Surgery and does not provide Inpatient accommodations. It must be operated under the supervision of a Physician. It also must provide nursing services by or under the supervision of a registered nurse (RN) who is on duty. The Facility must not be an office or Clinic for the private practice of a Physician. Ambulatory Surgical Center includes an endoscopy center.

Benefit Period: The Benefit Period begins on the Effective Date of your coverage under the Policy and lasts 365 days. Then a new Benefit Period will begin.

Blue Cross and Blue Shield of South Carolina: We, our, us.

Clinic: An Outpatient Facility for examining and treating patients who aren't bedridden. It must be operated under the supervision of a Physician.

Coinsurance: The percentage of Allowable Charges you pay as your share of Covered Services. The percentage of Coinsurance for Covered Services, payable by you, is applied to the negotiated rate or lesser charge when we have negotiated rates with your Provider for Covered Services provided by this Policy.

Contracting Facility: A Facility that has a written agreement with us.

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

Contracting Pharmacy: A Pharmacy that has a written contract with Blue Cross and Blue Shield of South Carolina or its Pharmacy Benefit Manager to fill a Prescription Order when a Blue Cross and Blue Shield ID card is presented. A Contracting Pharmacy will not charge the Covered Person more than the Allowable Charge for a Prescription Order.

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

Contracting Provider Agreement: A written agreement between Blue Cross and Blue Shield of South Carolina and a Provider.

Copayment (Per Occurrence Copayment): A fee you pay each time you receive a certain service or supply such as a doctor's office visit, a particular medical service, Hospital admission or prescription. Copayments are shown on the Schedule Page. If you purchased the Optional Prescription Drug Insurance Endorsement, the Prescription Drug Copayments are shown on the Prescription Drug Insurance Endorsement Schedule. Copayments don't go toward reaching your Deductible or Out-of-pocket Expense Limit. They will continue to apply even after you meet your Deductible and reach your Out-of-pocket Expense Limit.

Covered Person: You and each Dependent shown on the Schedule Page who is insured by this Personal BluePlan Policy.

Covered Service: A service or supply specified in this Policy for which a Covered Person is entitled to benefits according to the terms and conditions of this Policy.

Creditable Coverage: Health coverage subject to Health Insurance Portability and Accountability Act of 1996 (HIPAA). There must be no more than a 63-day break between two different health coverages.

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

It may be that credit for the period of this coverage will be given, if a future employer with a group Health Insurance plan has a Pre-existing Condition exclusion period, so long as there is no more than a 63-day break in coverage between this coverage and any succeeding coverage. If you leave the future group Health Insurance, the time of coverage under this Policy may help reduce a Pre-existing Condition exclusion period with the South Carolina Health Insurance Pool or another group health plan.

Custodial Care: Care that is determined by us to be provided primarily for the maintenance of the patient or designed to assist the patient in the activities of daily living. 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-administration of 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.

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

Designated Provider: Any Provider with whom we have a Contracting Provider Agreement, and that we require you to use for specialized services in order to receive benefits for these services. These Providers include, but are not limited to, Rehabilitation Facilities and Contracting Mammography Providers. When a Designated Provider does not perform these services, no benefits will be paid.

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 don't qualify because they don't have exclusive medical uses. To be considered Durable Medical Equipment, the device or equipment's use must be limited to the patient for whom it was ordered. This means others can't use the device or equipment.

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

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

Emergency Medical Condition: 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.

Facility: A Hospital, Skilled Nursing Facility, Ambulatory Surgical Center or Clinic.

Family Plan: A policy of insurance covering you and one or more of your Dependents.

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

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

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

Home Health Care: Home Health Care includes services you get in the home that are normally provided in a Hospital or Skilled Nursing Facility. You must receive Home Health Care from a home health agency that is licensed by the state in which it operates. We must approve benefits for Home Health Care in advance.

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

Hospital: A short-term, acute care Facility that:
1. Is licensed and operated according to the law; and
2. Is primarily and continuously engaged in providing or operating medical, diagnostic, therapeutic and major surgical Facilities for the medical care and treatment of injured or sick people on an Inpatient basis either on its premises or in Facilities available to the Hospital on a prearranged 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 or nervous conditions.

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

Inpatient: A Covered Person who is a registered bed patient in a Hospital, Skilled Nursing Facility, Rehabilitation Facility or Psychiatric/Substance Abuse Facility for whom a room and board charge is made.

Intensive Care Unit: A separate, clearly designated service area maintained within a Hospital and which meets all of the following tests:
1. It is solely for the treatment of patients who require special medical attention because of their medical conditions;
2. It provides within such area nursing care and observation of continuous and constant nature not available in regular rooms and wards of a Hospital;
3. It provides a concentration of special life-saving equipment immediately available at all times for the treatment of patients confined within such area;
4. It contains at least two beds for the accommodation of critically ill patients; and
5. It provides at least one registered nurse who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

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

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

   We will, however, allow coverage for a Prescription Drug that hasn't been approved by the FDA:
   a. For a specific medical condition when there are at least two formal clinical studies recognizing the use of the drug for the medical condition; or
   b. For the treatment of a specific type of cancer, provided the Prescription Drug is recognized for the treatment of that specific cancer in at least one standard reference compendium or the drug is found to be safe and effective in formal clinical studies. These results must have been published in peer-reviewed professional medical journals.

2. There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to let us evaluate the therapeutic value of the service.
3. There is inconclusive evidence that the service has a beneficial effect on a person's health.
4. The service under consideration is not as beneficial as any established alternatives.
5. There is insufficient information or inconclusive scientific evidence that the service is beneficial to the person's health and is as beneficial as any established alternatives when used in a noninvestigational setting.

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

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

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

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

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

Medical Supplies: Syringes and related supplies for conditions such as diabetes; dressings for conditions such as cancer or burns; catheters, external opening (ostomy) bags and related supplies; test tape; necessary supplies for renal dialysis equipment or machines; surgical trays; and splints or such supplies as needed for orthopedic conditions. However, supplies and equipment that have non-therapeutic uses are not covered medical expenses.

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

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

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

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

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

Non-contracting Facility: A Facility with whom we do not have a written agreement. No benefits are payable for services or supplies provided by a Non-contracting Facility, except for the treatment of an Emergency Medical Condition and services provided by a Non-contracting Facility located outside the State of South Carolina.

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.

Out-of-pocket Expense Limit: Covered Services for which benefits are not payable by us. The Out-of-pocket Expense Limit is made up of the Coinsurance amounts payable by you. It does not include any Deductibles or Copayments, Coinsurance amounts for Prescription Drugs, when shown on the Schedule Page, Coinsurance amounts for Mental Health Services and/or Substance Abuse care or Special Dental Services; 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 Policy.

Outpatient: A Covered Person who receives services or supplies in a setting that does not require an overnight stay.

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

Pharmacy: A facility that is licensed to prepare and dispense medications that a doctor prescribes. It doesn't include a Physician's office or for 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 benefits according to this Personal BluePlan Policy.

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

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

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

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

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

Preauthorization and Approval: The approval that must be obtained from Medical Services or Companion Benefit Alternatives, Inc. prior to receiving Inpatient Hospital and Skilled Nursing Facility services; Human Organ and/or Tissue Transplants; Inpatient Rehabilitation; Home Health Care and Hospice Care; Mental Health Services and/or Substance Abuse care (Inpatient and Outpatient); Outpatient Surgery, Outpatient Rehabilitation or any of the following procedures or supplies: Magnetic Resonance Imaging (MRI), Lithotripsy, Gastrointestinal Endoscopies (includes Colonoscopy, Sigmoidoscopy, Proctoscopy and Gastroscopy); Outpatient Physical Medicine; certain Prescription Drugs; and Prosthetic Appliances, Orthotic Devices and Durable Medical Equipment (DME) when the rental cost or purchase price is $500 or more.

Predetermination of Special Dental Services Benefits: The approval that must be obtained from us prior to receiving covered Special Dental Class I, Class II or Class III Services that your dentist or oral surgeon estimates will cost $250 or more.

Preferred Blue Facility: A Facility which has entered into a Preferred Blue Provider Agreement with us.

Preferred Blue Provider: A Provider which has entered into a Preferred Blue Provider Agreement with us.

Preferred Blue Provider Agreement: A written agreement between Blue Cross and Blue Shield of South Carolina and a Provider where the Provider agrees to accept our allowance as payment in full for Covered Services except that you are responsible for Deductibles, Copayments and Coinsurance.

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

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

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

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

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

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

Prescription Drug Coinsurance: The percentage of Allowable Charges for Prescription Drugs payable by the Covered Person.

Prescription Drug Deductible: The amount, if any, shown on the Schedule Page, of covered Prescription Drug charges each Covered Person is responsible for paying each Benefit Period before Prescription Drug benefits are payable.

Prescription Order: The request by a Physician for each separate Prescription Drug and each authorized refill.

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 Ambulatory Surgical Center licensed as required by the state where located, performing within the scope of the license and acceptable to us or as listed:

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

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

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

Rate of Payment: The percentage of Allowable Charges we will pay for Covered Services as shown on the Schedule Page and on your application after the Deductible and any Copayment is satisfied.

Rehabilitation Facility: A Hospital or other freestanding medical Facility that has a written agreement with us, that on an Inpatient or Outpatient basis, provides a multi-disciplinary 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.

Single Plan: A policy of insurance covering only you.

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's in charge of patient care along with one or more registered nurses (RNs) or licensed practical nurses (LPNs) on duty at all times; and
4. Keeps a daily medical record for each patient; and
5. Is primarily working to provide continuous skilled nursing care for sick or injured patients during the recovery stage of their illnesses or injuries and is not, other than incidentally, a rest home or a home for Custodial Care for the aged; and
6. Is operating lawfully as a nursing home in the area where it is located. In no event, however, will such term include an institution that primarily provides care and treatment of substance or alcohol abuse.

Special Dental Services Deductible: This is the amount of Allowable Charges for Special Dental Services you are responsible for paying each Benefit Period before benefits are payable on a claim for Covered Services.

Specialty Drugs: FDA approved Prescription Drugs that treat a complex clinical condition and/or require special handling such as refrigeration. They normally require unusual/complex clinical monitoring and special training. Specialty Drugs include but aren't limited to infusible specialty drugs for acute and chronic diseases, injectable and self-injectable drugs for acute and chronic diseases, biotechnology medicines and specialty oral drugs or other dosage forms.

Specialty Drug Copayment: The amount payable (if any) by the Covered Person for each Specialty Drug, as shown on the Schedule Page. The Specialty Drug Copayment will the Deductible or the Out-of-pocket Expense Limit shown on the Schedule Page and will continue to apply even after you reach your Out-of-pocket Expense Limit.

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

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

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

Urgent Care Claim: Any claim made by the Covered Person or by a Provider or Physician (with knowledge of the Covered Person's current medical condition), where, if the normal Pre-service Claim review time frames of this Contract were used:
1. The Covered Person's life, health or ability to regain maximum function could be seriously jeopardized; or
2. The Covered Person, 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 Policy. The Waiting Period begins on the day you substantially filled out your application and ends on the first day of coverage.

C. PREAUTHORIZATION AND APPROVAL

To make the most of your benefits, Blue Cross has an approval process in place. Our Medical Services personnel (a group of medical professionals employed by us) must give advance approval for all Hospital admissions and certain other specified services for you to receive maximum benefits. Their responsibility is to review all requests for preapproval. Inpatient and Outpatient services you receive for treatment of Mental Health Services and/or Substance Abuse care require Preauthorization by Companion Benefit Alternatives, Inc. (CBA). MRIs, MRAs, CT Scans, PET Scans and Nuclear Cardiology exams performed in an Outpatient Facility or a Physician's office require Preauthorization by National Imaging Associates.

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

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

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

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

Please note that if your request is denied for Preauthorization or preapproval for services or benefits, you may request further review under the guidelines set out in the *Appeals/Grievance Procedures* Section of this Policy. Also note that a Preauthorization and Approval denial will be considered a denied claim 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 or a Dependent is admitted to a Hospital or Skilled Nursing Facility, Preadmission Review approval must be obtained. If you've just had a baby, approval must be obtained within 24 hours of your discharge if your newborn is sick and must stay in the Hospital.

If approval isn't obtained, or if the admission isn't approved and you or your Dependent is still admitted, we won't pay benefits for any part of the room and board charges. If a Preferred Blue Hospital or Skilled Nursing Facility doesn't get approval, it can't bill you for room and board charges.

An admission for physical rehabilitation requires use of Designated Providers and Preauthorization from us. If the admission for physical rehabilitation isn't Preauthorized and/or the service isn't performed at a Designated Provider, no benefits will be paid.

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

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

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

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

If a Continued Stay Review approval isn't obtained, or if the continued stay isn't approved, but you or your Dependent remains in the Hospital or Skilled Nursing Facility, we won't pay benefits for any part of the room and board charges for the period of the continued stay. If a Preferred Blue Hospital or Skilled Nursing Facility doesn't get approval, it can't bill you for room and board charges for the continued stay.

Preauthorization Review — A number of services and medical procedures require Preauthorization Review:

- Home Health Care
- Hospice Care
- Physical rehabilitation
- Human organ and/or tissue transplants
- Certain Prescription Drugs
- Prosthetic Appliances, Orthotic Devices and Durable Medical Equipment when the purchase price or rental cost of the equipment is $500 or more.

Without advance written approval, benefits won't be paid for any part of the charges for Home Health Care, Hospice Care, human organ and/or tissue transplants, or Prosthetic Appliances, Orthotic Devices and Durable Medical Equipment when the purchase price or rental cost is $500 or more. If a Preferred Blue Provider doesn't get Preauthorization, it can't bill you for these charges.

Certain Prescription Drugs require Preauthorization. If Preauthorization isn't obtained, no benefits will be paid. Please contact the Claims Service Center to see if a specific drug requires Preauthorization.

Preauthorization also is required for Outpatient Surgery, Outpatient Physical Medicine and Outpatient procedures such as, but not limited to, magnetic resonance imaging (MRI), lithotripsies, gastrointestinal endoscopies including colonoscopies, sigmoidoscopies, esophagoscopies, proctoscopies and gastroscopies.

If you don't receive Preauthorization for any of these Outpatient procedures, benefits will be reduced as shown on the Schedule Page. If a Preferred Blue Provider doesn't get Preauthorization, it can't bill you for the reduction.

Outpatient physical rehabilitation requires use of Designated Providers and Preauthorization from us. If Outpatient physical rehabilitation isn't Preauthorized and/or the service isn't performed at a Designated Provider, no benefits will be paid.

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.

If approval isn't obtained for Inpatient Mental Health Services and/or Substance Abuse care, we'll deny covered charges for room and board. If approval isn't obtained for Outpatient Mental Health Services and/or Substance Abuse care, benefits will be reduced as shown on the Schedule Page.

If you need approval, be sure to call Medical Services or Companion Benefit Alternatives, Inc. **Please don't call the Claims Service Center. A Claims Service Representative cannot give approval. Please refer to the *How to Contact Us* provision for the telephone numbers to call for approval.**

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

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

After careful review, your Physician and Hospital will be notified whether the admission or service is approved as Medically Necessary and how long the approval is valid.

Predetermination of Benefits for Special Dental Services

If you need Special Dental Services treatment that the dentist or oral surgeon estimates will cost $250 or more, the dentist or oral surgeon should file a Predetermination of Benefits to us. By doing this, you and the Provider will know in advance how much will be paid for the recommended treatment.

To file for Predetermination of Benefits, the Provider should list the planned treatment and charges for the treatment on a dental claim form. The form should be sent to the Dental Claims Unit, Blue Cross and Blue Shield of South Carolina, Post Office Box 100300, Columbia, SC 29202. We will advise both you and the Provider of the benefits payable.

If treatment costs $250 or more and the Provider doesn't ask for Predetermination of Benefits, claims will be paid according to the information on the claim.

Predetermination of Benefits isn't needed for Special Dental Services treatment costing less than $250 or for emergency care, routine oral examinations, x-rays, fluoride treatments, cleaning, scaling or polishing teeth.

D. COVERED SERVICES

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

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

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

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

The following are Covered Services:

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

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

Cleft Lip and Palate – The Medically Necessary care and treatment of a cleft lip and palate and any condition or illness that is related to or caused by a cleft lip and palate. Cleft lip and palate means a congenital cleft in the lip or palate or both. Care and treatment will include, but is 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 Covered Person with a cleft lip and palate is also covered by a dental policy, then teeth capping, prosthodontics and orthodontics will be covered by the dental policy to the limit of coverage provided and any excess after that will be provided by this Policy.

Complications of Conditions due to Pregnancy – A life-threatening condition needing medical treatment during and 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.

Dental Services Related to Accidental Injury – 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 Policy.

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

The purpose of the Diabetes Initiative of South Carolina is to establish a statewide program of education, surveillance, clinical research and translation of new diabetes treatment methods to serve the needs of state residents.

Services and payment for diabetes education programs will conform to regulations of the U.S. Department of Health and Human Services published according to Section 4105 of the Balanced Budget Act of 1997. Diabetes self-management training and education will be provided on an Outpatient basis when done by a registered or licensed health care professional that is certified in diabetes. This certification must be from the National Certification Board of Diabetes Educators, or other accredited program approved by the Diabetes Initiative of South Carolina, or by the Diabetes Control Program of the S.C. Department of Health and Environmental Control.

Diagnostic Services – Medically Necessary procedures ordered by a Physician because of specific symptoms to determine a definite condition or disease. Benefits will be provided on an Inpatient and Outpatient basis. Diagnostic services provided on an Inpatient basis that could have been safely done on an Outpatient basis will not be provided. Diagnostic services include, but are not limited to:

1. Radiology, ultrasound and nuclear medicine;
2. Laboratory and pathology. This does not include services for sexual dysfunction and infertility;
3. ECG, EEG, and other electronic diagnostic medical procedures and physiological medical testing;
4. Surgical pathology — pathological examination of tissue removed surgically, by resection or biopsy, on an Outpatient basis. This 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 Covered Person'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 Page. Please refer to your Schedule Page 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 Page. Benefits do not include a TENS unit; or manual or motorized wheelchairs or power operated scooters for mobility outside the home setting. We must determine the devices are Medically Necessary to assist with mobility in the home for benefits to be available. No Benefits are provided for repair, replacement or duplicates, nor are benefits provided for services related to the repair or replacement of DME, except when necessary due to a change in the Covered Person's medical condition, and with prior authorization from us. Repair or replacement for routine wear and tear is not a covered expense.

Emergency Medical Care by Non-contracting Facilities – If you or a covered Dependent receives Emergency Medical Care from a Non-contracting Facility, benefits for Covered Services will be paid at a Rate of Payment shown on the Schedule Page if you meet all of these conditions:

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

Benefits under this provision are subject to the Deductible, the non-Preferred Blue Provider Copayments and Out-of-pocket Expense Limit and to all Policy maximums, limits and exclusions.

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

If you have claims that meet all these conditions, you should write or call the Claims Service Center. Your claims will be reviewed to determine if benefits can be provided at a Rate of Payment shown on the Schedule Page.

Home Health Care Services – When provided to a homebound Covered Person in the Covered Person's home. Home Health Care must be provided by, or through a community home health agency, must be provided on a part-time visiting basis and must be provided according to a Physician-prescribed course of treatment. Preauthorization based on established Home Health Care treatment must be obtained from us before you are eligible. Please refer to your Schedule Page 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 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 isn't needed when we approve the entire Home Health Care plan).

Hospice Care – We must Preauthorize Hospice Care before you are eligible for this care. Benefits are payable as specified in the Schedule Page. The services must be provided according to a Physician prescribed treatment plan. Please refer to your Schedule Page 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 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 isn't needed when we approved the entire Hospice Care plan);
10. Respite care; and
11. Family counseling concerning the patient's terminal condition.

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

    The day that a Covered Person 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 Covered Person returns to the Hospital is treated as the day of admission and is counted as an Inpatient care day. The days during which a Covered Person 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 from us. If written Preauthorization isn't obtained, no benefits will be paid 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 you receive for human organ and/or tissue transplants while you are covered under this Policy. This includes donor organ procurement.
1. Kidney transplants for patients with dialysis dependent kidney failure and liver transplants are the only living donor, human organ transplants covered under this Policy. 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 Covered Persons, benefits will be provided for both;

b. When the transplant recipient is a Covered Person and the donor is not, benefits will be provided for both the recipient and the donor to the extent that benefits to the donor are not provided by any other source. This includes, but is not limited to, other insurance coverage, any government program or any employee welfare plan. Benefits provided to the donor will be charged against the recipient's coverage under this Policy;

c. When the transplant recipient is not a Covered Person and the donor is, no benefits will be provided to either the donor or the recipient.

2. Limited benefits are provided for the specified major human organ transplant procedures listed below. These benefits are subject to all other provisions of the Policy.
   - Kidney single/double, pancreas and kidney, heart, lung single/double, liver, pancreas, heart and lung single/double 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. Transplants of tissue (rather than whole major organs), except fetal tissue, are covered expenses under this Policy, subject to all the provisions of this Policy only as follows:
   - Blood transfusions (but not whole blood and blood plasma);
   - Autologous parathyroid transplants;
   - Corneal transplants;
   - Bone and cartilage grafting; or
   - Skin grafting.

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

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

Medical Supplies – Benefits are payable for Medically Necessary supplies.

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

The Benefit Period Maximum is shown in the Schedule Page.

Amounts a Covered Person pays for Mental Health Services and/or Substance Abuse care will not apply toward the Out-of-pocket Expense Limit and the payment for these services do not increase when the Out-of-pocket Expense Limit 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 Page.

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

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

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

1. Surgical Services
   a. Special Services – Reconstructive Surgery to restore bodily function or correct deformity resulting from disease, trauma, congenital anomalies or developmental anomalies.

   b. Multiple Surgical Procedures – When multiple surgical procedures are performed through the same incision or body opening during one operation, benefits are provided only for the primary procedure, unless more than one body system is involved or the procedures are required for management of multiple trauma.

      If two or more surgical procedures are performed through different incisions or body openings during one operation, benefits are provided for the additional procedures at 50 percent of the Allowable Charge for each procedure. 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.

      Certain surgical procedures, which are normally exploratory in nature, are designated as "Independent Procedures" by us and the Allowable Charge is covered when such a procedure is performed as a separate and single entity. However, when an Independent Procedure is performed as an integral part of another surgical service, the total amount covered will be the Allowable Charge for the major procedure only.

   c. Anesthesia – Administration of anesthesia ordered by the attending Physician and provided by a Physician other than the surgeon or assistant at Surgery.

2. Inpatient Services – Medical care (except for routine nursery charges and the first medical exam of a newborn well baby) provided by a Physician to a Covered Person, as a patient in a Hospital for a condition not related to Surgery or pregnancy, except as specifically provided herein. Benefits will not be provided for tests or treatment as an Inpatient that could have been safely done as an Outpatient.

   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 Covered Person'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.

   Benefits are not payable for daily medical visits by more than one Physician unless the Covered Person has a separate medical condition the attending Physician can't treat. In this type of situation, benefits may be payable for one daily visit by each Physician.

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

3. Outpatient Medical Services – Medical care provided by a Physician to a Covered Person in an Outpatient setting for a condition not related to Surgery or pregnancy, except as specifically provided. Outpatient medical services do not include charges for telephone consultations, failure to keep a scheduled appointment, completion of claim forms or for furnishing medical records.
    a. Emergency Medical Care – The treatment of an Emergency Medical Condition.

    b. Non-Routine Office Visits – Medical care visits and consultation for the examination, diagnosis and treatment of an injury or illness. Eligible Physician charges do not include "virtual office visits" on the Internet. A "virtual office visit" on the Internet occurs when the Physician, "treating," consulting, diagnosing, writing or approving a prescription, has never physically seen or physically examined the Covered Person.

        This benefit is subject to the Preferred Blue Physician's Non-Routine Office Visit Copayment as shown on the Schedule Page and is not subject to the Deductible. The Preferred Blue Physician's Non-Routine Office Visit Copayment will apply even when the Deductible has been met.

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

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

Prescription Drugs must be consistent with the diagnosis and treatment of a covered illness, injury or condition; or not excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care. Benefits for the daily dosage of a Prescription Drug will be provided as recommended as described in the current *Physician's Desk Reference* or as recommended under the guidelines of our Pharmacy Benefit Manager, whichever is lower.

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

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

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

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 doesn't change when we receive any financial credit. Copayments are flat amounts and likewise don't change when we receive drug manufacturer or PBM credits.

Some Prescription Drugs require Preauthorization by us prior to being filled. Please contact the Claims Service Center to see if a specific drug requires Preauthorization. If you don't get the required Preauthorization, no benefits will be provided.

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

Specialty Drugs are not covered under this benefit.

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

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

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

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

If you purchased the Drug Card, you (or your covered Dependent) must pay the Contracting Pharmacy:
1. The Prescription Drug Deductible, if applicable; and
2. The Prescription Drug Copayment or the Contracting Pharmacy's usual, reasonable and customary charge that would be charged to a non-Covered Person, whichever is less; and
3. Any type of service charge including the administration or injection of a Prescription Drug; or
4. 100 percent of the cost of a Prescription Order when a Covered Person fails to show their ID card.

If a Contracting Pharmacy is not used and your benefits include coverage for a non-Contracting Pharmacy, you (or your covered Dependent) must:
1. Pay the Pharmacy in full for the Prescription Order; and
2. File a claim form with us for reimbursement. The claim form must be obtained from us.

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 and Administration.
- Preventive prostate screenings and lab work according to the American Cancer Society (ACS) guidelines

These services are provided In-network only.

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

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

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

Skilled Nursing Facility Services – Services in a Skilled Nursing Facility. These services must: 1) follow the onset of an injury or illness that occurred after the Effective Date; and 2) begin within 14 days after being discharged from a Hospital following an authorized hospitalization.

Specialty Drugs: A Physician must prescribe Specialty Drugs. The prescription must be filled by a Specialty Drug Network Provider. Benefits for covered Specialty Drugs dispensed to you shall not exceed the quantity and benefit maximum, if any, as shown on your Schedule Page. You may obtain 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**.

Specialty Drugs must be consistent with the diagnosis and treatment of a covered illness, injury or condition; or not excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care.

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

Any Coinsurance percentage that you must pay for Specialty Drugs is based on the Allowable Charge at the Specialty Drug Network Provider. It 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.

Benefits will not be provided or paid for the following:
1. Service charges or handling fees for a Specialty Drug; or
2. Specialty Drugs that are not Medically Necessary.

Therapy Services
1. Short-term Therapy Services – Services must be Medically Necessary, ordered by a Physician, performed by a licensed therapist and provide to promote the recovery of the Covered Person 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 is shown in the Schedule Page.

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.

D.1 ADDITIONAL SERVICES

Discounted Services

Discounts for certain additional services and products are available to Covered Persons through networks that Blue Cross contracts with for a wide range of health and wellness programs. Services may include, but are not limited to: chiropractic, massage therapy, acupuncture, vitamin and herbal supplements, laser eye surgery (LASIK) and hearing aids. All services and programs may not be available in all areas and at all times.

These are added-value discount programs. The discounts on services and products are offered to Blue Cross policyholders in addition to the benefits covered under your Policy. **Blue Cross is not responsible for any costs associated with these programs**.

To receive these special discounts, all you have to do is show your ID card when you receive any of these services. There are no claims to file.

For more details on these programs, visit our website at www.SouthCarolinaBlues.com or refer to your Value Added Advantage Brochure.

E. 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.

F. SPECIAL DENTAL SERVICES

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

Benefits for covered Special Dental Services are paid at the Rate of Payment as shown on the Schedule Page. Class II and III are subject to the Special Dental Services Deductible as shown the Schedule Page.

The Maximum Payment per Covered Person per Benefit Period is shown on the Schedule Page. The Special Dental Services Maximum Payment is for all Classes combined.

Special Dental Services benefits are payable to one dentist or oral surgeon. If you transfer 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 Related to Accidental Injury section of this Policy.

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 you have 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 you have supplementary bitewing x-rays after this coverage becomes effective.
   d. Cleaning, scaling, and polishing of teeth once each Benefit Period.
   e. Fluoride treatment for the Covered Person if he or she is under age 19, once each Benefit Period.
   f. Emergency palliative treatment for pain relief.
   g. Space maintainers for prematurely lost deciduous (baby) teeth for the Covered Person if he or she is under age 19.
   h. Diagnostic casts not made in conjunction with any type of prosthodontics (Class III).
   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.
   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 you get 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 "Exclusions and Limitations" Section of this Policy for Exclusions and Limitations applicable to the Special Dental Services.

Special Dental Services Waiting Period

Beginning with the Effective Date of your coverage under this Policy, there is a 12-month waiting period for Class III Dental Services.

These waiting periods do not apply in cases of emergency if there is no previous medical history of the condition prior to the Effective Date of your coverage.

G. CONTINUATION OF CARE

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

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

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

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

H. PRE-EXISTING CONDITION LIMITATION

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

A Pre-existing Condition is a condition:

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

Pre-existing Conditions do not apply to Covered Persons who obtains this coverage prior to age 19 or include congenital anomalies of a covered Dependent child.

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

I. EXCLUSIONS AND LIMITATIONS

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

1. Treatment provided in a government Hospital that you are not legally responsible for; or for which benefits are provided under Medicare or other governmental programs (except Medicaid);
2. Any charges for services or supplies for which you are entitled to payment or benefits (whether or not you have applied for such payment or benefits) under any motor vehicle no-fault law;
3. Injuries or diseases paid by workers' compensation (if a workers' compensation claim is settled, then we'll consider it paid by workers' compensation);
4. Separate charges for services provided by employees of Hospitals, laboratories or other institutions; for services or supplies performed or furnished by a member of the Covered Person's immediate family; and for services for which a charge is normally not made in the absence of insurance;
5. Cosmetic Surgery: Cosmetic Surgery does not include reconstructive Surgery when services are incidental to or following Surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive Surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect;

6. Illness contracted or injury sustained as the result of: war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or an auxiliary unit;

7. Rest cures and Custodial Care;

8. Transportation, except as shown in *Covered Services*;

9. Routine physical examinations, except as shown in *Covered Services*;

10. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. This exclusion does not include corrective Surgery or treatment for metabolic or peripheral vascular disease;

11. Dental care or treatment, except as shown in *Covered Services* and provided under *Special Dental Services*, as follows:
    - 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 coverage.
    - 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 Special Dental Services that are part of a treatment plan approved by us before the cancellation date if the services are completed within 30 days of the date the treatment plan was approved.
    - Treatment that is more expensive than necessary. If you or your dentist or oral surgeon choose a course of treatment that is more expensive than that of other Providers, benefits are payable for the less costly procedure if it is consistent with accepted standards of dental practice.
    - Services or supplies for which the provider does not charge.
    - 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.

12. Eyeglasses; contact lenses (except after cataract Surgery) and hearing aids and examinations for their prescribing or fitting;

13. Normal pregnancy or childbirth, except as provided when the Optional Maternity Endorsement is purchased. Your Schedule Page will show if you have purchased the Optional Maternity Endorsement;

14. Treatment, services or supplies received as a result of suicide, attempted suicide or intentionally self-inflicted injuries whether the patient was sane or insane;

15. Treatment, services or supplies received in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the body for purposes of removing nerve interference and the effects of such nerve interference, where such interference is the result of or related to distortion, misalignment or subluxation of, or in, the spinal column; or

16. Any service or supply related to dysfunctional conditions of the muscles of mastication or derangement of the temporomandibular joint (TMJ), including office visits, splints, braces, guards, etc. This exclusion, however, will not apply to Medically Necessary surgical correction of disorders of TMJ. As used in this exclusion, Medically Necessary surgical correction of TMJ means: surgical correction of skeletal malrelationships or deformities of the jaws that cause documented chronic, persistent pain or debilitating loss of function and have required treatment or medication. The presence of a documented congenital anomaly alone does not establish medical necessity. Preauthorization is required.

J. OTHER POLICY PROVISIONS

1. **Claim Forms:** When we receive notice of a claim, we will send the claimant forms for filing proof of loss.

2. **Conformity with State Statutes:** Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the state in which it is delivered on that date is amended to conform to the minimum requirements of such laws.

3. **Entire Policy; Changes:** This Policy, together with the application and any attached papers, is the entire Policy between you and Blue Cross and Blue Shield of South Carolina. No agent can change it in any way. Only an officer of ours can approve a change. That change must be shown on your Policy.

4. **Governing Law:** This Policy and all endorsements and amendments issued hereunder will be construed according to and controlled by the applicable laws and regulations of the State of South Carolina.

   The Health Insurance Portability and Accountability Act of 1996 (HIPAA) became a law on August 21, 1996. This law affects group and individual health plans. It includes important protections for individuals, including those who move from one job to another or who are self-employed, and who have Pre-existing Conditions.

5. **Grace Period:** This Policy has a 31-day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period the Policy will stay in force.

6. **Illegal Occupation:** We are not liable for any loss that results from the Covered Person committing, or attempting to commit a felony or from a Covered Person engaging in an illegal occupation.

7. **Intoxicants and Narcotics:** We are not liable for any loss resulting from the Covered Person being intoxicated or under the influence of any narcotic unless taken on the advice of a Physician.

8. **Legal Actions:** No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy. No such action may be brought after six years from the time written proof of loss is required to be given.

9. **Meetings of Insured Persons:** While this Policy is in force, you are a member of Blue Cross and Blue Shield of South Carolina. You are entitled to vote at any meeting of members. Our annual meeting is held at our Home Office in Columbia, South Carolina, on the first Thursday of April. Notice of the annual meeting is given by your acceptance of this Policy. We will mail you notice of any special meeting of members 30 days before such meeting.

10. **Misstatements of Age:** If any relevant fact about a person to whom the insurance relates has been misstated, the true facts will be used to determine whether the insurance is in force and in what amount. If the age of a Covered Person has been misstated and if the amount of the premiums is based on age, an adjustment in premiums, coverage, or both, will be made based on the Covered Person's true age. No misstatement of age will continue insurance otherwise validly terminated or terminate insurance otherwise validly in force. This Policy is issued to individuals from birth up to 64 years of age or Medicare eligibility, whichever occurs first.

11. **Non-assessable:** This is a Non-assessable Policy. You, the Policyholder, are not subject to any assessment for any contingent liability. This means that if, for any reason, we owe money, you are not responsible for paying it.

12. **Notice of Claim:** Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice may be given to us at our home office or to our agent. Notice should include the name of the Covered Person and the Policy number.

13. **Other Valid Coverage; Proration:** This Policy is not meant to duplicate other valid coverage you have with other Health Insurance policies. “Other Valid Coverage” is defined as Health Insurance coverage that is similar to the coverage provided by this Policy, coverage provided by hospital or medical service organizations, coverage provided by union welfare plans or employee benefit organizations, but not group or individual Health Insurance with us.

    If you have Other Valid Coverage, we will “prorate” benefit payments when your claim is received. We will carefully consider all of the valid Health Insurance that covers your claim. We will determine our responsibility for your loss in proportion to the responsibility that should be accepted by other insurance companies, and we will pay the portion of your claim we are responsible for.

    If your claim is prorated, the portion of the premiums you paid for coverage that we did not accept as our responsibility will also be prorated. This will be based on premiums paid during the time both policies were in effect and the treatment was being provided.

14. **Payment of Claims:** We will pay all benefits directly to the Policyholder when we receive written proof of loss. The Policyholder is expressly prohibited from assigning any benefits due unless we determine otherwise. We will pay benefits as described in this Policy directly to the Provider if we have a written agreement for direct payment of benefits with that Provider.

15. **Physical Examinations:** We have the right to have a Physician examine any person as often as reasonably necessary while a claim is pending or after our Medical Services staff has been contacted for review of medical services. We will pay for the cost of these examinations. We may also have an autopsy done during the period of contestability unless prohibited by law. The autopsy must be performed in South Carolina.

16. **Proofs of Loss:** Written proof of loss must be furnished to us at our said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event, except in the absence of legal capacity, will written proofs of loss be furnished later than one year from the time the proof is otherwise required.

17. **Reinstatement:** If any renewal premium is not paid within the time granted, the Policy will lapse. We may reinstate the Policy, provided:
    a. You complete an application for reinstatement; and
    b. The unpaid premium is not more than 60 days overdue; and
    c. You pay all overdue premiums (note: you will be given a conditional receipt for the premium); and
    d. You furnish evidence of insurability, if required; and
    e. We approve your request for reinstatement.

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

    Reinstated insurance will provide benefits, subject to all conditions in this Policy, for:
    a. Injury sustained on or after the reinstatement date; and
    b. An illness that begins more than 10 days after the reinstatement date.

    Reinstated insurance will provide benefits under any Endorsement(s) attached to the Policy only for services that begin after the date of reinstatement. After the Policy is reinstated, you and Blue Cross will have the same rights as existed just before the due date.

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

19. **Subrogation Right:** We may exercise our subrogation right if:
    a. A claim is made to us for an illness or injury that results in charges under this Policy; and
    b. A third party that, in our opinion may be liable, is reasonably expected to reimburse you for those charges, we will be subrogated and will succeed to individual rights of recovery against such third party to the full extent of the amount of benefits paid by us. You should, at our request, give us any information we may need and sign any documents that may be required to assist us in recovering this amount, and do nothing to prejudice our subrogation rights. We will pay our portion of attorney fees and costs incurred in pursuing our subrogation recovery.

    You have the right to petition the Director of the Department of Insurance to determine if our subrogation action is inequitable or unjust.

    Subrogation means that we are allowed to recover the amount of medical benefits we have paid at the time you settle a lawsuit or a judge or jury awards you money resulting from an accident.

20. **Time Limit On Certain Defenses:** After two years from the issue date only fraudulent misstatements in the application may be used to void the Policy or deny any claim for loss incurred or disability that starts after the two year period.

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

22. **Unpaid Premium:** When a claim is paid, any premium due may be deducted from the claim payment.

AMENDMENT TO THE PERSONAL BLUE[SM] POLICY

(Policy form numbers listed below)

Women's Health Care Amendment

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

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

This Amendment to the Policy is effective on or after August 1, 2012.

The Policy is revised as follows:

Section B. Definition is revised as follows:

Benefit Period is deleted in its entirety and the following substituted:

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.

Section D. Covered Services, second paragraph, number 6. is deleted in its entirety and the following substituted:

6. Not be for pre-conception testing or pre-conception genetic testing;

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

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

Section D. Covered Services is revised as follows:

Physician Services, the first paragraph is deleted in its entirety and the following substituted:

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

Prescription Drugs, the second paragraph is deleted in its entirety and the following substituted:

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

Section E. 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.

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

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.SouthCarolinasBlues.com)

James A. Deyling
President
Blue Cross and Blue Shield Division