Schedule of Benefits for Personal True Blue℠

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
13038M-A 13040M-A	Personal True Blue Personal True Blue Limited Benefits Health Insurance	Your Premium
	Blue Rx Basic Card Secure Card Generic Card Drug Card	Type of Drug Coverage Chosen and Premium
	Optional Dental and Vision Coverage	Premium or Not Purchased
	Optional Accident Medical Expense	Premium or Not Purchased
	Optional Maternity	Premium or Not Purchased
	Total <u>Monthly</u> Premium	Total Prmeium

Schedule of Benefits for Personal True Blue

(continued)

Deductible – You pay

Single	Family
In-Network Providers / Out-of-Network Providers	In-Network Providers / Out-of-Network Providers
Plan 1 – $2,000 / $4,000	Plan 1 – $4,000 / $8,000
Plan 2 – $3,500 / $7,000	Plan 2 – $7,000 / $14,000
Plan 3 – $2,000 / $4,000	Plan 3 – $4,000 / $8,000
Plan 4 – $3,500 / $7,000	Plan 4 – $7,000 / $14,000

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

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

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

Copayments – You pay

$35 Primary Care Physician
$60 Specialists for Plans 1 and 2
$100 Emergency Room for Plans 1 and 2
$75 Emergency Room for Plans 3 and 4
$150 Outpatient Visit
$250 Inpatient Admissions

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

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

Plans 3 and 4 do not have a Specialist Copayment.

Out-of-pocket Maximum – You pay

Single	Family
In-Network Providers / Out-of-Network Providers	In-Network Providers / Out-of-Network Providers
All Plans	All Plans
$5,000 / $10,000	$15,000 / $30,000

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

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

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

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

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	After the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
Primary Care Physician (PCP) (not including Mental Health Services and/or Substance Abuse Care) 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	After the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
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)	Plans 1 and 2 – 100% after Copayment Plan 3 – 80% after the Deductible Plan 4 – 60% after the Deductible	After the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%

	WE PAY IN-NETWORK PROVIDERS	WE PAY OUT-OF-NETWORK PROVIDERS
Physician office 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	After the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
Endoscopies (such as colonoscopy, proctoscopy and laparoscopy) performed in a Physician's office, whether for diagnosis or treatment	After the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
High technology diagnostic services such as, but not limited to, MRIs, MRAs, PET scans, CT scans, ultrasounds, cardiac catheterizations, and procedures performed with contrast or dye	After the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
Inpatient Physician charges for admissions in a Hospital and Skilled Nursing Facility, Surgery, anesthesia, radiology and pathology services	After the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
Preventive Benefits		
Preventive screenings are covered according to the following: • The United States Preventive Services Task Force (USPSTF) recommended Grade A or B screenings. • Immunizations as recommended by the Center for Disease Control (CDC). • Screenings recommended for children and women by Health Resources and Services Administration	100%	Not Covered
Preventive prostate screening and laboratory work according to the guidelines of the American Cancer Society	100%	Not Covered

	WE PAY MAMMOGRAPHY NETWORK PROVIDERS	WE PAY OUT-OF-NETWORK PROVIDERS
Preventive mammography screening when provided by a Contracting Mammography Provider	100%	Not Covered

	WE PAY IN-NETWORK PROVIDERS	WE PAY OUT-OF-NETWORK PROVIDERS
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	After the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	Not covered

Schedule of Benefits for Personal True Blue
(continued)

	WE PAY IN-NETWORK PROVIDERS	WE PAY OUT-OF-NETWORK PROVIDERS
Other Services		
Out-of-country services or supplies (including Facility and Physician)	After the Copayment and the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Copayment and the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
Ambulance	After the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
Home Health Care with the required Preauthorization	After the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
Inpatient and Outpatient Hospice Care with the required Preauthorization	After the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
Short-Term Therapy (physical, occupational and speech therapy)	After the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
Other Therapy Services	After the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
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.	After the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	Not Covered
Medical Supplies	After the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
Prosthetic Devices	After the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
Dental Care due to accidental injury to Sound Natural Teeth	After the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
Mental Health Services and/or Substance Abuse Care	(1) Inpatient/Outpatient – After the Copayment and the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	(1) Inpatient/Outpatient – After the Copayment and the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
	(2) Physician's Services – After the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	(2) Physician's Services – After the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
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.	After the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%

Schedule of Benefits for Personal True Blue
(continued)

	WE PAY IN-NETWORK PROVIDERS	WE PAY OUT-OF-NETWORK PROVIDERS
Facility Benefits		
Inpatient Hospital (other than Skilled Nursing Facility or Mental Health Services and/or Substance Abuse Care)	After the Copayment and Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Copayment and Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
Skilled Nursing Facility	After the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
Inpatient Rehabilitation services when Preauthorized by us	After the Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%
Outpatient Hospital Emergency Room charges. The Copayment is waived if the Member is admitted to the Hospital on the same day and for the same condition.	After the Copayment and Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Copayment and Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%
Outpatient Hospital or Clinic charges for medical and surgical services, preadmission testing, lab and X-ray services and all other miscellaneous services	After the Copayment and Deductible, Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60%	After the Copayment and Deductible, Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40%

Drug Card

	WE PAY CONTRACTING MAIL SERVICE PHARMACY	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: $16 for Generic Drugs $70 for Preferred Drugs $140 for 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	Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 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	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: $70 for Preferred Drugs $140 for Non-preferred Drugs Benefits are limited to a 90-day supply.	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

Schedule of Benefits for Personal True Blue
(continued)

Secure Card

	WE PAY CONTRACTING MAIL SERVICE PHARMACY	WE PAY PARTICIPATING NETWORK PHARMACY	WE PAY NON-PARTICIAPTING NETWORK PHARMACY
Prescription Drugs			
Secure Card Generic, Preferred and Non-Preferred Drugs	100% per prescription or refill after you pay the Prescription Drug Copayment of: $25 for Generic Drugs $115 for Preferred Drugs $190 for Non-preferred Drugs	100% per prescription or refill after you pay the Prescription Drug Copayment of: $10 for Generic and designated Over-the-counter Drugs $45 for Preferred Drugs $75 for Non-preferred Drugs	No Benefits
Generic Oral Birth Control	100% per prescription or refill	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: $115 for Preferred Drugs $190 for Non-preferred Drugs Benefits are limited to a 90-day supply.	100% per prescription or refill after you pay the Prescription Drug Copayment of: $45 for Preferred Drugs $75 for Non-preferred Drugs Benefits are limited to a 31-day supply or a 90-day supply with 3 Prescription Drug Copayments.	No Benefits

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

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

Schedule of Benefits for Personal True Blue
(continued)

Generic Card

	WE PAY CONTRACTING MAIL SERVICE PHARMACY	WE PAY PARTICIPATING NETWORK PHARMACY	WE PAY NON-PARTICIAPTING NETWORK PHARMACY
Prescription Drugs			
Generic Card Generic Drugs	100% per prescription or refill after you pay the Prescription Drug Copayment of: $20 for Generic Drugs and Diabetic Brand-name Drugs when there is no Generic Drug equivalent (single source Brand-name Drug)	100% per prescription or refill after you pay the Prescription Drug Copayment of: $10 for Generic and designated Over-the-counter Drugs only and Diabetic Brand-name Drugs when there is no Generic Drug equivalent (single source Brand-name Drug)	No Benefits
Generic Oral Birth Control	100% per prescription or refill	100% per prescription or refill	No Benefits
Preferred and Non-Preferred Oral Birth Control	No Benefits Benefits are limited to a 90-day supply.	No Benefits Benefits are limited to a 31-day supply or a 90-day supply with 3 Prescription Drug Copayments.	No Benefits

	WE PAY SPECIALTY DRUG NETWORK PROVIDERS	WE PAY ALL OTHER PHARMACY PROVIDERS
Specialty Drugs		
	No Benefits	No Benefits

Schedule of Benefits for Personal True Blue
(continued)

Blue Rx℠

	WE PAY CONTRACTING MAIL SERVICE PHARMACY	WE PAY PARTICIPATING NETWORK PHARMACY	WE PAY NON-PARTICIPATING NETWORK PHARMACY
Prescription Drugs			
Blue Rx Generic, Preferred and Non-Preferred Drugs	Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60% per prescription or refill after the Deductible	Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60% per prescription or refill after the Deductible	Plans 1 and 3 pay at 60% Plans 2 and 4 pay at 40% per prescription or refill after the Deductible
	Benefits are limited to a 90-day supply.	Benefits are limited to a 31-day supply.	Benefits are limited to a 31-day supply.
	Birth control, contraceptives and contraceptive devices are not covered.	Birth control, contraceptives and contraceptive devices are not covered.	Birth control, contraceptives and contraceptive devices are not covered.
Generic Oral Birth Control	100% per prescription or refill	100% per prescription or refill	No Benefits
Preferred and Non-Preferred Oral Birth Control	Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60% per prescription or refill after the Deductible	Plans 1 and 3 pay at 80% Plans 2 and 4 pay at 60% per prescription or refill after the Deductible	No Benefits
	Benefits are limited to a 90-day supply.	Benefits are limited to a 31-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

Basic Card

	WE PAY CONTRACTING MAIL SERVICE PHARMACY	WE PAY PARTICIPATING NETWORK PHARMACY	WE PAY NON-PARTICIAPTING NETWORK PHARMACY
Prescription Drugs			
Basic Card Generic, Preferred and Non-Preferred Drugs	100% per prescription or refill after you pay the Prescription Drug Copayment of: $25 for Generic Drugs (Tier 1) $115 for Preferred Drugs (Tier 2) $190 for Non-preferred Drugs (Tier 3)	100% per prescription or refill after you pay the Prescription Drug Copayment of: $15 for Generic and designated Over-the-counter Drugs (Tier 1) $60 for Preferred Drugs (Tier 2) $75 for Non-preferred Drugs (Tier 3)	No Benefits
Generic Oral Birth Control	100% per prescription or refill	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: $115 for Preferred Drugs (Tier 2) $190 for Non-preferred Drugs (Tier 3) Benefits are limited to a 90-day supply.	100% per prescription or refill after you pay the Prescription Drug Copayment of: $60 for Preferred Drugs (Tier 2) $75 for Non-preferred Drugs (Tier 3) Benefits are limited to a 31-day supply or a 90-day supply with 3 Prescription Drug Copayments.	No Benefits

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

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

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

Dental and Vision Coverage

Dental and Vision Coverage — Purchased or Not Purchased

Dental Coverage

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

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

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

Vision Benefits

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

Accident Medical Expense

Accident Medical Expense — Purchased or Not Purchased

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	5%
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 TRUE BLUE SM
MAJOR MEDICAL EXPENSE COVERAGE WITH LIMITED BENEFITS FOR HUMAN ORGAN AND/OR TISSUE TRANSPLANTS

Guaranteed Renewable Except for Stated Reasons

You may renew this Policy on any premium due date by paying the premium required at the time of renewal and within the grace period. We may non-renew, rescind or issue a Rider to the Policy:

1. If you don't pay the premiums according to the terms of the Policy or if we have not received timely premium payments; or
2. If you commit fraud or intentionally misrepresent a material fact related to insurability under the terms of the Policy; or
3. If we decide to discontinue offering Personal True Blue for everyone who has this Policy. However, we my only discontinue coverage if we:
   a. Provide notice to each individual covered by this Policy of the discontinuance at least 90 days before the date the Policy is discontinued;
   b. Offer to each individual covered by this Policy, the option to purchase other individual Health Insurance coverage we currently offer; and
   c. Act uniformly without regard to any Health Status-related Factor of enrolled individuals or individuals who may become eligible for coverage in exercising the option to discontinue the Policy or offer the option to purchase other individual coverage.
4. At the time of renewal, we may modify this Policy for everyone who has it as long as the modification is consistent with state law and effective on a uniform basis.

However, won't decline to renew your Policy simply because your physical or mental health changes or your Dependents' physical or mental health changes after your Policy's Effective Date.

Premium Rate Subject to Change

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

Right to Examine Policy for 30 Days

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

BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA

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

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 the *Preauthorization and Approval* section of this Policy for details. If you or your Physician doesn't get proper Preauthorization and Approval, Allowable Charges may be subject to a benefit payment reduction or non-payment.

Important Notice
Concerning Statements in Your
Application for Insurance

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

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

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 help you understand your Policy.

To make sure your claims are handled properly, our process involves evaluation and Preauthorization certain services 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 costs.

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

How to Contact Us

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

For Customer Services Inquiries:
If you have any questions about your eligibility, changes to your Policy or rates, please contact the Individual Membership Department. We can be reached by telephone, mail or through our website.

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

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

Telephone Numbers: (Monday through Friday, 8:30 a.m. to 5:30 p.m. Eastern Standard Time)
803-264-3475 (from the Columbia area)
800-868-2500, ext. 43575 (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®

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)

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.

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.

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:

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

My Health Toolkit

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

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

When Your Coverage Begins and Ends

Eligibility: This Policy is available to you and your spouse if you are both under age 64½ and live in South Carolina. Your dependent children may also be eligible for coverage if they are under age 26 at the time you apply for coverage. Proof of health is required for a spouse and child unless the child is a newborn or is adopted and an application and any premium that may be due is submitted within 31 days of birth or adoption.

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

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

For an adopted child, coverage will start when you pay the appropriate premium, if any, as follows:
1. From the moment of birth for a child you or your spouse legally adopts within 31 days of the date of the child's birth;
2. From the moment of birth for a child for whom you or your spouse has temporary custody and have begun adoption proceedings within 31 days of the child's birth; or
3. When the adopted child is not a newborn, upon temporary custody with your or your spouse. Coverage will continue as long as you or your spouse has custody of the child.

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

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

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

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

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

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

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

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

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

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

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

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

The terms Totally Disabled/Total Disability mean the Member is unable to perform the duties of his or her occupation and is under the care of a Physician. A child who is Totally Disabled is receiving ongoing medical care by a Physician and unable to perform the normal activities of a child in good health of the same age and sex.

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

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

Deductible, Out-of-pocket Maximum and Maximum Benefits

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

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

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

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

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

Benefit Period Maximum: The Benefit Period Maximum is shown on the Schedule of Benefits.

Preferred Blue® Providers (In-network Providers)

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

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

Your In-network Provider has agreed to:
1. Bill you no more for Covered Services than the Blue Cross Preferred Blue network allowance.
2. File all claims for Blue Cross covered services for you.
3. Ask you to pay only the required Deductibles, Copayments and Coinsurance for covered amounts.

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

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

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

Out-of-network Providers (All Other Providers)

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

We encourage you to use In-network Providers whenever you can for a number of reasons. Out-of-network Providers may:
1. Require you to pay the full amount of their charges at the time you receive services.
2. Require you to file your own claims.
3. Require you to get all necessary Approvals. Information regarding how and when to get an Approval is in the *Preauthorization and Approval* section.
4. Charge you more than the Blue Cross Allowed Charge.

How to File Claims

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

If you receive health care services or supplies from an Out-of-network Provider or non-Contracting Provider, you'll have to file your own claims. Please follow the instructions below when you have claims for expenses other than Prescription Drugs. When filing your own claims, here are some things you'll need:
1. **Comprehensive Benefits Claim Form for each patient.** You can get these forms from the Claims Service Center or from our 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 Purchased at a Non-Contracting Pharmacy (if this Policy provides benefits for non-contracting Pharmacies): To file your claim for Prescription Drugs:
1. Use a Prescription Drug claim form. You can get these forms from the Claims Service Center or from our website at www.SouthCarolinaBlues.com.
2. Fill out the top half of the form, sign it and attach the receipt for the Prescription Drugs.
3. Mail the form to the contracting Pharmacy Benefit Manager at the address shown on the form.

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

B. DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Creditable Coverage: Health coverage under any public or private insurance plan, as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). There must be no more than a 63-day break between two different health coverages.

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

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

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

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

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

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

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

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

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

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

Emergency Medical Condition: An illness or injury so severe that a reasonable person with an average knowledge of health and medicine could reasonably expect that if he or she doesn't get medical care right away, one of these might occur:
1. Serious risk to one's health. If a woman is pregnant this includes her health or her unborn child's health; or
2. Serious damage to organ, body functions or body parts.

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

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

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

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

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

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

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

The term Hospital doesn't include long-term, chronic care institutions or institutions that are, other than incidentally:
1. Convalescent, rest or nursing homes or Facilities; or
2. Facilities primarily affording custodial, educational or 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 doesn't include a long-term, chronic-care institution or Facility which mainly provides care for items (1) through (4) above, whether or not such institution or Facility is affiliated with or part of a Hospital.

Incapacitated Dependent Child: The limiting age doesn't apply to a Dependent child who becomes and continues to be: 1) incapable of self-sustaining employment because of mental or physical handicap or disability; and 2) mainly dependent upon the Policyholder or Policyholder's spouse for support and maintenance. The child must have developed the handicap before he or she reached the age at which coverage would otherwise terminate. To keep coverage for an Incapacitated Dependent Child, you must give us written proof from a Physician of the disability within 31 days of the Dependent' 26th birthday. For the child to remain covered, we must receive a Physician's written report every two years within 31 days of the child's birthday. If your coverage ends for any reason, coverage for an Incapacitated Dependent Child will also end.

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

Investigational or Experimental: The use of treatments, procedures, facilities, equipment, drugs, devices, services or supplies (herein collectively referred to as a "service") that we don't recognize as standard medical care for the treatment of conditions, diseases, illnesses or injuries. We may use the following criteria to determine whether a service is Investigational or Experimental:
1. The service requires Federal or other governmental agency approval such as drugs and devices that have restricted market approval from the Food and Drug Administration (FDA) or from any other governmental regulatory agency for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.

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

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

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

Our Medical Director, in making such determinations, may consult with or use one or more of these sources of information:
1. FDA-approved market rulings;
2. *The United States Pharmacopoeia and National Formulary*;
3. The annotated publication titled, *Drugs, Facts, and Comparisons*, published by J. B. Lippincott Company;
4. Available peer-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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pharmacy: A Provider that is licensed to dispense medications a doctor prescribes. It doesn't include a Physician's office or 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 benefit program according to this Policy.

Physician: A person (other than an intern, resident or house Physician) duly licensed as a medical doctor, oral surgeon, 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 Member's surgical procedure. Pre-admission Testing doesn't 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 Member's condition, but is not a guarantee or verification of Benefits. Payment is subject to Member's eligibility, Pre-existing Condition Limitations and all other Contract limitations and exclusions. Final Benefit determination will be made when the Company processes the Member's claim.

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

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

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

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

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

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

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

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

Prescription Drug Deductible: The amount, if any, shown in the Schedule of Benefits, of covered Prescription Drug charges each Member is responsible for paying each Benefit Period before Prescription Drug benefits are payable. This is a separate Deductible and won't apply to your Benefit Period Deductible or the Out-of-pocket Maximum.

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

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

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

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

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

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

Rehabilitation Facility: A Hospital or other freestanding medical Facility that has a written agreement with us to provide on an Inpatient or Outpatient basis, a 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.

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

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.

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

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

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

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

Specialty Drugs (including generic Specialty Drugs): FDA approved Prescription Drugs that treat a complex clinical condition and/or require special handling such as refrigeration. They normally require unusual/complex clinical monitoring and special training. Specialty Drugs include but 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 Member for each Specialty Drug, as shown on the Schedule of Benefits. The Specialty Drug Copayment will not apply to the Prescription Drug Deductible (if any), the Specialty Drug Deductible (if any), the Deductible, the Specialty Drug Out-of-pocket Maximum (if any) or the Out-of-pocket Maximum shown in the Schedule of Benefits and will continue to apply even after your reach your Specialty Drug Out-of-pocket Maximum (if any) and/or the Policy Out-of-pocket Maximum.

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

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

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

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

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

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

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

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

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

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

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

C. PREAUTHORIZATION AND APPROVAL

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

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

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

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

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

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

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

Types of Approval

There are five different types of approval:

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

Here are more details about each one:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. COVERED SERVICES

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

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

1. Be prescribed by or performed by or upon the direction of a Physician; and
2. Be done for diagnosis or treatment of a Member's illness or injury, except as specifically noted herein; and
3. Be approved as Medically Necessary and appropriate; and
4. Not be Investigational or Experimental in nature; 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 don't 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 Member's home or the scene of an accident or medical emergency to a Hospital or between Hospitals when such Hospital is the closest Facility that can provide Covered Services appropriate to the Member's condition. If there is no Hospital in the local area that can provide Covered Services appropriate to the Member's condition, the ambulance service provides transportation to the closest Hospital outside the local area that can provide the necessary service.

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

Cleft Lip and Palate – The Medically Necessary care and treatment of a cleft lip and palate and any condition or illness that is related to or caused by a cleft lip and palate. Cleft lip and palate means a congenital cleft in the lip or palate or both.

Care and treatment will include, but isn't limited to these types of Medically Necessary care:

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

If a Member with a cleft lip and palate is also covered by a dental policy, then teeth capping, prosthodontics and orthodontics will be covered by the dental policy to the limit of coverage provided and any excess after that will be provided by this 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 to Sound Natural Teeth 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, Outpatient self-management training and education for the treatment of Members with diabetes if it's Medically Necessary and a health care professional prescribes it. This health care professional must be legally authorized to prescribe such items and follow minimal standards of care for diabetes. These minimal standards of care are adopted and published by the Diabetes Initiative of South Carolina.

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

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

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

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

Emergency Medical Care by Non-contracting Facilities – If you or a covered Dependent receives Emergency Medical Care from a non-contracting Facility, we'll provide benefits for Covered Services at a rate of payment shown on the Schedule of Benefits 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 applicable Deductibles and Out-of-pocket Maximums and to all Policy maximums, limits and exclusions.

Coverage under these circumstances continues only so long as the Emergency Medical Condition exists. A Preferred Blue Provider or Non-preferred Blue Provider must provide any follow-up care for services to be covered.

If you have claims that meet all these conditions, you should write or call the Claims Service Center. We'll review your claims to see if we can pay benefits at a rate of payment shown on the Schedule of Benefits.

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

1. Services by a registered nurse (RN) or licensed practical nurse (LPN);
2. Physical, speech and occupational therapy (the Short-term Therapy Benefit Period Maximum applies);
3. Services 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 of Benefits. The services must be provided according to a Physician prescribed treatment plan. Please refer to your Schedule of Benefits to see what benefit limitations apply. Hospice Care includes:
1. Services provided by a registered nurse (RN) or licensed practical nurse (LPN);
2. Physical, speech and occupational therapy (the Short-term Therapy Benefit Period Maximum applies);
3. Services 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 – Benefits don't include routine nursery charges.
1. Inpatient Hospital Services – Include:
    a. A semi-private room and special care unit – When a Member is admitted to a Hospital in which all rooms are private, the most prevalent semi-private room rate, as determined by us, will be considered the private room allowance;
    b. Bed and board – including meals, special diets and general nursing services;
    c. Ancillary services, such as:
        1. Use of operating, delivery and treatment rooms;
        2. Prescribed drugs;
        3. Administration of blood and blood processing;
        4. Anesthesia, anesthesia supplies and services provided by an employee of the Hospital;
        5. Medical and surgical dressings, supplies, casts and splints;
        6. Diagnostic services;
        7. Therapy services; and
        8. Rental of Hospital equipment up to the purchase price during the Inpatient stay.

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

Benefits for covered transplants are subject to Deductibles and Copayments.

Organ transplant coverage includes all expenses for medical and surgical services and supplies you receive for human organ and/or tissue transplants while you are covered under this Policy. This includes donor organ procurement. Organ transplants don't include transplants involving mechanical or animal organs.
1. Benefits are provided for living donor, human organ transplants subject to the following conditions:
    a. When both the transplant recipient and the donor are Members, benefits will be provided for both.
    b. When the transplant recipient is a Member and the donor isn't, benefits will be provided for both the recipient and, to the extent benefits remain and are available under this Policy, for the donor after the recipient's own expenses have been provided. Benefits provided to the donor will be charged against the recipient's coverage under this Policy.
    c. When the transplant recipient isn't a Member and the donor is, no benefits will be provided to either the donor or the recipient.

2. Limited benefits are provided for the specified major human organ transplant procedures listed below. These benefits are subject to all other provisions of the Policy.
   - Single/double kidney, pancreas and kidney, heart, single/double lung, liver, pancreas, heart and single/double lung and bone marrow transplants.

3. Benefits may be available when a malignancy is present for high dose chemotherapy followed by hematopoietic stem support, either autologous (the patient is the donor) bone marrow transplant, peripheral stem cell or allogeneic bone marrow transplant when the procedure is considered Medically Necessary.

4. Benefits may be available for allogeneic bone marrow transplantation in the treatment of developmental and non-malignant diseases of bone marrow when the procedure is considered Medically Necessary.

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

5. The following expenses related to transplants of tissue (rather than whole major organs), except fetal tissue, are covered, subject to all the provisions of this Policy:
   - 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 and physical complications for all stages of mastectomy including lymphedemas. This includes Surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance as determined in consultation with the attending Physician and the patient.

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

Mental Health Services and/or Substance Abuse Care – We'll provide benefits as shown in the Schedule of Benefits, for Mental Health Services and/or Substance Abuse care when a Member is a patient in a Hospital or Psychiatric/Substance Abuse Facility or is receiving Outpatient services. Mental Health Services and/or Substance Abuse care don't include 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 doesn't include services for Animal Assisted Therapy, rTMS, Eye Movement Desensitization and Reprocessing (EMDR), behavioral therapy for solitary maladaptive habits or Rapid Opiate Detoxification.

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

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

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

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

Out-of-country – We'll 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 Member 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. Reconstructive Surgery – to restore bodily function or correct deformity resulting from disease, trauma, congenital anomalies or developmental anomalies. For the purposes of this Policy, Reconstructive Surgery doesn't include Cosmetic, plastic or other types of surgical services or Physician Services stated above that aren't covered as stated above.

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

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

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

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

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

2. Inpatient Services – Medical care (except for routine nursery charges and the first medical exam of a newborn well baby) provided by a Physician to a Member, as a patient in a Hospital for a condition not related to Surgery or pregnancy, except as specifically provided herein. We won't pay benefits for Inpatient tests or treatment that could have been safely done on an Outpatient basis.

   a. Inpatient Medical Care Visits – Visits are limited to one per day. Inpatient medical services also include diagnostic services and therapy services done concurrently with medical care.

   b. Intensive Medical Care – If a Member's condition requires intensive medical care, benefits are payable for one intensive medical care visit a day by the attending Physician.

   c. Consultation – A consultation from another Physician may be ordered by a patient's attending Physician. For each consulting Physician, benefits are payable for one consultation during a single admission to a Hospital or Skilled Nursing Facility.

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

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

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

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

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

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

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

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

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 of Benefits. You must have a valid prescription for these classes of Over-the-counter Drugs.

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

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

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

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

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

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

Benefits won't be provided or paid for the following:
1. Service charges or handling fees for a Prescription Drug;
2. More than the number of days supply shown on the Schedule of Benefits;
3. Prescription refills in excess of the number specified on the prescription or refills dispensed more than one year after the original prescription date;
4. Prescription Drugs for Pre-existing Conditions or 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 of Benefits. If benefits are available, non-Contracting Pharmacies can charge you more than the Allowable Charge. Benefits for drugs purchased from non-Contracting Pharmacies will be paid at a lower percentage.

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

If a Contracting Pharmacy is not used 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. The Benefit Period Maximum is shown on the Schedule of Benefits.

Specialty Drugs (including generic Specialty Drugs) – Please refer to your Schedule of Benefits to see if benefits for Specialty Drugs are included in your coverage. A Physician must prescribe Specialty Drugs. The prescription must be filled by a Specialty Drug Network Provider. Benefits for covered Specialty Drugs dispensed to you shall not exceed the quantity and benefit maximum, if any, as shown in your Schedule of Benefits. You may obtain a list of Specialty Drugs by contacting the Claims Service Center or you can get the list from our Web site at www.SouthCarolinaBlues.com. Preauthorization is required for benefits to be available.

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

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

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

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

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

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

   The Benefit Period Maximums are shown on the Schedule of Benefits.

2. Other Therapy Services
   a. Chemotherapy — The treatment of malignant disease by chemical or biological antineoplastic agents that have received full, unrestricted market approval from the FDA.

   b. Dialysis Treatment — The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or retinol dialysis. Dialysis treatment includes home dialysis.

   c. Radiation Therapy — The treatment of disease by X-ray, radium or radioactive isotopes.

Temporomandibular Joint Disorder (TMJ) – Benefits will be provided for Medically Necessary surgical correction of disorders of TMJ. Medically Necessary surgical correction of TMJ means: surgical correction of skeletal malrelationships or deformities of the jaws that cause documented chronic, persistent pain or debilitating loss of function and have required treatment or medication. The presence of a documented congenital anomaly alone doesn't establish Medical Necessity. Preauthorization is required. Benefits do not include office visits, splints, braces, guards, etc.

D.1 OPTIONAL COVERED SERVICES

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

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

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

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

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

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

Covered Services include only:
1. Pre-natal services normally associated with a Pregnancy. Pre-natal services include the following when Medically Necessary: pre-natal profile, Pregnancy test and blood tests including immunoglobulin, hemoglobin and glucose tolerance tests; ultrasound/echography; urinalysis; vaginal culture; chlamydia study; pelvimetry, fetal non-stress or stress tests; rhogam injection and cerclage.
2. Medically Necessary delivery services normally associated with a vaginal delivery, including the use of pitocin and other labor inducing drugs and stillbirth after 26 weeks.
3. Routine newborn nursery care from the moment of birth until the child is discharged from the Hospital, if the child is added to the Policy within 31 days of birth.

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

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

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

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

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

Maternity benefits do not include the following:
1. Charges for educational materials.
2. Charges for infertility diagnosis and treatment, including but not limited to drugs, artificial insemination, in-vitro fertilization, surrogate Pregnancy, fees associated with sperm banking, sterilization or reversal of sterilization.
3. Complications of Pregnancy, as defined, are covered under the regular policy benefits and not under this optional benefit. Charges incurred due to Complications of Pregnancy will be subject to the Deductible, Coinsurance and all other Policy provisions.

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

E. 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. 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.

G. PRE-EXISTING CONDITION LIMITATION

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

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

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

A diagnosis isn't required for a condition to be a Pre-existing Condition.

Pre-existing Conditions don't apply to Members who obtain this coverage prior to age 19.

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

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

H. EXCLUSIONS AND LIMITATIONS

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

1. Treatment provided in a government Hospital that you aren't 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're entitled to payment for benefits (whether or not you have applied for such payment or benefits) under any motor vehicle no-fault law.
3. Injuries or diseases paid by Workers' Compensation or settlement of a Workers' Compensation claim.
4. Separate charges for services provided by employees of Hospitals, laboratories or other institutions; for services or supplies performed or furnished by a member of the Member's immediate family; and for services for which a charge is normally not made in the absence of insurance.
5. Cosmetic Surgery except that cosmetic Surgery doesn't include reconstructive Surgery incidental to or following Surgery resulting from trauma, infection or other diseases of the involved part, or reconstructive Surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect.
6. Illness contracted or injury sustained as the result of: war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or an auxiliary unit.
7. Rest cures and Custodial Care.
8. Transportation, except as shown in *Covered Services*.
9. Routine physical examinations, except as shown in *Covered Services*.
10. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. This exclusion doesn't include corrective Surgery or treatment for metabolic or peripheral vascular disease.
11. Dental care or treatment, except as shown in the Schedule of Benefits. However, removal of impacted teeth is never covered.
12. Eyeglasses, except as shown in the Schedule of Benefits; contact lenses (except after cataract Surgery) and hearing aids and examination for their prescribing or fitting.
13. Normal pregnancy or childbirth, except as provided when the Optional Maternity coverage is purchased. Your Schedule of Benefits will show if you have purchased the Optional Maternity coverage.

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

15. Services, care or supplies used to detect and correct, by manual or mechanical means structural imbalance, distortion or subluxation in your body for the purpose of removing nerve interference and its effects when this interference is the result of or related to distortion, misalignment or subluxation of, or in, the spinal column.

I. GRIEVANCE/APPEALS 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, Social Security number and any other information, documentation, medical records or evidence to support your request. You must submit your formal grievance within 90 days of the event that resulted in your complaint.

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

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

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

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

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

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

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

   We will notify you or your authorized representative of the lack of information from which to render a decision within 24 hours from receipt of the original Urgent Care Claim. An extension of 48 hours may be required if we do not receive complete information in which to make a Medical Necessity decision. If we do not receive the required information from you within 48 hours after notifying you, the claim may be denied.

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

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

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

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

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

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

How to File an Appeal
If you wish to file a formal **appeal**, you must write to Blue Cross and Blue Shield of South Carolina, Customer 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, we'll notify you 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'll 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.

I. OTHER POLICY PROVISIONS

1. **Claim Forms:** When we receive notice of a claim, we'll send the claimant forms for filing proof of loss. If these forms aren't provided to you within 15 days, you will meet the Proof of Loss requirement by giving us a written statement of the nature and extent of the loss within the time limits stated in the Proofs of Loss provision.

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

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

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

5. **Grace Period:** This Policy has a 31-day grace period for the payment of premium. This means that if a renewal premium isn't paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period the Policy will stay in force. If the premium hasn't been paid by 12:01 a.m. of the day following the end of the Grace Period, the Policy will automatically terminate as of the premium due date without further notice to you.

6. **Illegal Occupation:** We will not provide benefits for any loss that results from the Member committing, or attempting to commit a felony or from a Member engaging in an illegal occupation.

7. **Intoxicants and Narcotics:** We will not provide benefits for any loss resulting from the Member being legally intoxicated or impaired, by being under the influence of alcohol, any narcotic or drug unless taken on the advice of a Physician. The Member or Member's representative must provide any available test results, upon our request, showing blood alcohol or drug levels if the Member refuses to provide these test results, no benefits will be paid.

8. **Legal Actions:** No legal action may be brought to recover on this Policy until 60 days after we have received a claim (notice and proof of loss) as required by this Policy. You can't bring any such action after six years from the time you are required to give written proof of loss.

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

10. **Misstatements:** If the age of a Member has been misstated and if the amount of the premiums is based on age, an adjustment in premiums, coverage, or both, will be made based on the Member's true age. No misstatement of age will continue insurance that has been otherwise validly terminated or terminate insurance otherwise validly in force. This Policy is issued to individuals from birth up to 64½ years of age or Medicare eligibility, whichever occurs first.

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

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

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

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

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

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

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

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

17. **Reinstatement:** If any renewal premium isn't paid within the Grace Period, the Policy will lapse automatically without further notice to you. We may reinstate the Policy, in our sole discretion, if:
    a. You complete an application for reinstatement; and
    b. The unpaid premium isn't 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'll refund the premium submitted.

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

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

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

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

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

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

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

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

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

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

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

22. **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.

23. **Unpaid Premium:** When we pay a claim, we may deduct any premium due 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

AMENDMENT TO YOUR BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA POLICY

(An Independent Licensee of the Blue Cross and Blue Shield Association,
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Repeal of Optional Intoxications and Narcotics Exclusion Amendment

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

- Personal Blue Basic
- Personal Blue Secure
- Personal True Blue

This Amendment to the Policy is effective on or after the Benefit Period of your Policy starting January 1, 2018.

Definitions, is amended by the deletion of the following:

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

Other Policy Provisions, is amended by the deletion of the following:

Intoxicants and Narcotics: We will not provide benefits for any loss resulting from the Member being legally intoxicated or impaired, by being under the influence of alcohol, any narcotic or drug unless taken on the advice of a Physician. The Member or Member's representative must provide any available test results, upon our request, showing blood alcohol or drug levels If the Member refuses to provide these test results, no benefits will be paid.

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

Scott Graves
President
Blue Cross and Blue Shield Division

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)