

# BLUE CROSS<sup>®</sup> AND BLUE SHIELD<sup>®</sup> OF SOUTH CAROLINA

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

COLUMBIA, SC 29219

([www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com))

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

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

## PERSONAL BLUEPLAN<sup>SM</sup> HIGH DEDUCTIBLE MAJOR MEDICAL EXPENSE COVERAGE WITH LIMITED BENEFITS FOR HUMAN ORGAN AND/OR TISSUE TRANSPLANTS POLICY FORM NO. 12221M OUTLINE OF COVERAGE

### Read Your Policy Carefully

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

### Major Medical Expense Coverage

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

### Preauthorization Requirement

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

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

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

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

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

## Benefit Description

Benefit Choices	<p>You choose one of the following benefit options: 100/60 or 80/60.</p> <p>Personal BluePlan allows you to use Blue Cross' Preferred Blue Provider network*. These Providers will file your claims to Blue Cross, get approvals from Blue Cross, charge no more than the Preferred Blue Provider allowance and ask you to pay only Deductibles and Coinsurance.</p> <p>* All references to the Preferred Blue Provider network also include the National and International BlueCard® PPO network.</p>																	
Lifetime Maximum Payment for Each Covered Person	<p>\$2,000,000 including \$10,000 for Mental Health Services and/or Substance Abuse care (Inpatient and Outpatient combined), \$100,000 for Inpatient Physical Rehabilitation and the Transplant Lifetime Maximums for each Covered Person. The Transplant Lifetime Maximums are the maximum amounts we will pay for each of the following transplants. For transplants not listed, we will determine the Transplant Lifetime Maximum on an individual basis.</p> <table border="0" style="margin-left: 40px;"> <tr> <td>• Kidney, single/double</td> <td style="text-align: right;">\$60,000</td> </tr> <tr> <td>• Pancreas and kidney</td> <td style="text-align: right;">\$150,000</td> </tr> <tr> <td>• Heart</td> <td style="text-align: right;">\$120,000</td> </tr> <tr> <td>• Lung, single/double</td> <td style="text-align: right;">\$150,000</td> </tr> <tr> <td>• Liver</td> <td style="text-align: right;">\$200,000</td> </tr> <tr> <td>• Pancreas</td> <td style="text-align: right;">\$80,000</td> </tr> <tr> <td>• Heart and single/double lung</td> <td style="text-align: right;">\$200,000</td> </tr> <tr> <td>• Bone Marrow</td> <td style="text-align: right;">\$200,000</td> </tr> </table>		• Kidney, single/double	\$60,000	• Pancreas and kidney	\$150,000	• Heart	\$120,000	• Lung, single/double	\$150,000	• Liver	\$200,000	• Pancreas	\$80,000	• Heart and single/double lung	\$200,000	• Bone Marrow	\$200,000
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Benefit Period Maximum Payment for Each Covered Person	Short-term therapy services	\$1,000																
Deductible	<p>Deductible choices for a Single Plan are:</p> <p style="margin-left: 40px;"><b>100/60 Option</b> \$1,500, \$2,600, \$3,500, or \$5,000</p> <p style="margin-left: 40px;"><b>80/60 Option</b> \$1,500, \$2,600, or \$3,500</p> <p>Deductible choices for a Family Plan are:</p> <p style="margin-left: 40px;"><b>100/60 Option</b> \$3,000, \$5,200, \$7,000, or \$10,000</p> <p style="margin-left: 40px;"><b>80/60 Option</b> \$3,000, \$5,200, or \$7,000</p> <p>The family Deductible is an aggregate maximum.</p> <p>The Deductible applies to all Covered Services unless specified otherwise.</p>																	
Copayments	<p>\$0 Copayment – Admissions to Preferred Blue Facilities</p> <p>\$0 Copayment* – Admission to Non-preferred Blue Facilities</p> <p>*The Deductible also applies.</p> <p>Copayments do not go toward reaching the Out-of-pocket Expense Limit and will continue even after the Out-of-pocket Expense Limit has been met.</p>																	
Out-of-pocket Expense Limit	<p>If you choose Single coverage with:</p> <p>100/60 Option with \$1,500 Deductible, the Out-of-pocket Expense Limit will be \$1,500 for Preferred Blue Providers and \$3,000 for Non-preferred Blue Providers</p> <p>100/60 Option with \$2,600 Deductible, the Out-of-Pocket Expense Limit will be \$2,600 for Preferred Blue Providers and \$5,200 for Non-preferred Blue Providers</p> <p>100/60 Option with \$3,500 Deductible, the Out-of-Pocket Expense Limit will be \$3,500 for Preferred Blue Providers and \$5,500 for Non-preferred Blue Providers</p> <p>100/60 Option with \$5,000 Deductible, the Out-of-Pocket Expense Limit will be \$5,000 for Preferred Blue Providers and \$10,000 for Non-preferred Blue Providers</p>																	

80/60 Option with \$1,500 Deductible, the Out-of-pocket Expense Limit will be \$3,000 for Preferred Blue Providers and \$4,500 for Non-preferred Blue Providers

80/60 Option with \$2,600 Deductible, the Out-of-Pocket Expense Limit will be \$5,200 for Preferred Blue Providers and \$7,800 for Non-preferred Blue Providers

80/60 Option with \$3,500 Deductible, the Out-of-Pocket Expense Limit will be \$5,500 for Preferred Blue Providers and \$7,500 for Non-preferred Blue Providers

If you choose Family coverage with:

100/60 Option with \$3,000 Deductible, the Out-of-pocket Expense Limit will be \$3,000 for Preferred Blue Providers and \$6,000 for Non-preferred Blue Providers

100/60 Option with \$5,200 Deductible, the Out-of-Pocket Expense Limit will be \$5,200 for Preferred Blue Providers and \$10,400 for Non-preferred Blue Providers

100/60 Option with \$7,000 Deductible, the Out-of-Pocket Expense Limit will be \$7,000 for Preferred Blue Providers and \$11,000 for Non-preferred Blue Providers

100/60 Option with \$10,000 Deductible, the Out-of-Pocket Expense Limit will be \$10,000 for Preferred Blue Providers and \$20,000 for Non-preferred Blue Providers

80/60 Option with \$3,000 Deductible, the Out-of-pocket Expense Limit will be \$6,000 for Preferred Blue Providers and \$9,000 for Non-preferred Blue Providers

80/60 Option with \$5,200 Deductible, the Out-of-Pocket Expense Limit will be \$10,400 for Preferred Blue Providers and \$15,600 for Non-preferred Blue Providers

80/60 Option with \$7,000 Deductible, the Out-of-Pocket Expense Limit will be \$11,000 for Preferred Blue Providers and \$15,000 for Non-preferred Blue Providers

The Out-of-pocket Expense Limit for a Family Plan is an aggregate maximum.

Out-of-pocket Expenses are portions of Covered Services that each Covered Person must pay. Deductibles (unless specified otherwise) and Coinsurance for Mental Health Services and/or Substance Abuse care apply to the Out-of-pocket Expense Limit. Charges in excess of the Allowable Charge, amounts exceeding any Maximum Payments for benefits; Coinsurance amounts for maternity when the Optional Maternity Endorsement is purchased and non-covered amounts do not apply to the Out-of-pocket Expense Limit.

Covered Services will be paid at 100% of Allowable Charges for both Preferred Blue Providers and Non-preferred Blue Providers (except Non-contracting Facilities) for the rest of the Benefit Period when the Out-of-pocket Expense Limit is reached.

Non-contracting  
Facilities

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

Emergency  
Medical Care By  
Non-contracting  
Facilities

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

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

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

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

The BlueCard Program

The “BlueCard Program” means the program in which all Blue Cross and Blue Shield Plans participate. This program benefits Blue Cross and Blue Shield members who receive Covered Services outside the geographic area that Blue Cross and Blue Shield of South Carolina serves. Blue Cross and Blue Shield of South Carolina is your home plan – the entity with which you have the policy. The Blue Cross and Blue Shield Plan where you are is treated is the “Host Plan.”

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

- The billed charges for your Covered Services; or
- The negotiated price that the Host Blue Cross and/or Blue Shield Plan passes on to us.

The Host Plan is only responsible for contracting with its participating out-of-area Providers and handling all interaction with its participating out-of-area Providers under the BlueCard Program.

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

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

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

### Covered Services

Daily Hospital Room and Board	Semi-private room or intensive care unit.
Other Covered Hospital Services	Ancillary Hospital services; Outpatient Hospital services; Outpatient Surgery; Emergency Medical Care; Outpatient diagnostic, X-ray and lab services.
Physician Services	Surgery; administration of anesthesia; daily Hospital medical care; Outpatient services; treatment of accidents; non-routine office visits.
Therapy Services	When approved by us as Medically Necessary and ordered by a Physician. Short-term therapy services are limited to a Benefit Period maximum shown in the <i>Benefit Description</i> section.

Preventive Benefits	<p><u>Routine OB-GYN Examination</u> – 100% of Allowable Charges for any female Covered Person, limited to two examinations annually. The services must be provided by a Preferred Blue Provider and don't include lab and X-ray.</p> <p><u>Routine Pap Smear Screening</u> – 100% of Allowable Charges. Benefits are limited to one per Benefit Period for any female Covered Person, or more often if recommended by a medical doctor. A Preferred Blue Provider must provide the services.</p> <p><u>Routine prostate Examinations Screening and Laboratory Work</u>) – 100% of Allowable Charges when performed according to the most recently published guidelines of the American Cancer Society (Web site: <a href="http://www.cancer.org">www.cancer.org</a>). A Preferred Blue Provider must provide the services.</p> <p><u>Routine Physical Examinations</u> – 100% of Allowable Charges for routine physical examinations or well-child care and immunizations, limited to \$300 in Benefits per Covered Person per Benefit Period. A Preferred Blue Provider must provide the services.</p>
Routine Mammography Services	100% of Allowable Charges for any female Covered Person according to the most recently published guidelines of the American Cancer Society (Web site: <a href="http://www.cancer.org">www.cancer.org</a> ). A Contracting Mammography Provider must provide the services.
Home Health Care	Medical services for the first 40 Home Health Care visits per Benefit Period.
Hospice Care	Medically Necessary services when ordered by a Physician and when the patient is diagnosed with less than six months to live.
Prescription Drugs	<p>We pay higher benefits for the most cost-effective Prescription Drugs available at the time the prescription is filled, including the use of Generic Drugs, according to all legal and ethical standards. Prescription Drugs must be consistent with the diagnosis and treatment of a covered illness, injury or condition, or not excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care. Benefits for the daily dosage of a Prescription Drug will be provided as recommended as described in the current <i>Physician's Desk Reference</i> or as recommended under the guidelines of our Pharmacy Benefit Manager, whichever is lower.</p> <p>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.</p> <p>Prescription Drugs exclude birth control, contraceptives and contraceptive devices.</p> <p>Specialty Drugs are not covered under this benefit.</p> <p><b>Benefits won't be provided or paid for the following:</b></p> <ol style="list-style-type: none"> <li>1. Service charge or handling fee for a Prescription Drug.</li> <li>2. Prescription Drugs that aren't Medically Necessary.</li> </ol> <p>Prescription Drugs received from a contracting Pharmacy – After the Deductible has been satisfied, benefits will be based on the option you chose and are limited to a 31-day supply.</p> <p>Prescription Drugs received from a non-contracting Pharmacy – After the Deductible has been satisfied, benefits will be based on the option you chose and are limited to a 31-day supply.</p>

Specialty Drugs	<p>A Physician must prescribe Specialty Drugs. A Specialty Drug Network Provider must fill the prescription drug. Benefits will not exceed the amount for which prior approval was given. You may obtain a list of Specialty Drugs by contacting the Claims Service Center or you can get the list from our Web site at <a href="http://www.SouthCarolinaBlues.com">www.SouthCarolinaBlues.com</a>.</p> <p>Specialty Drugs – Per Dose Specialty Drug Network Providers – After the Deductible, benefits will be based on the option you chose.</p> <p>All other Pharmacy Providers – No Benefits.</p> <p>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. <b>Preauthorization is required for Benefits to be available.</b></p> <p>Benefits will not be provided or paid for the following:</p> <ol style="list-style-type: none"> <li>1. Service charges or handling fees for a Specialty Drug.</li> <li>2. Specialty Drugs that are not Medically Necessary.</li> </ol>
Other Covered Services	<p>Dental services related to accidental injury; Prosthetic Appliances, Orthotic Devices and Durable Medical Equipment; oxygen and equipment for its use; Medical Supplies; ambulance service; blood and blood plasma; out-of-country services and supplies.</p>

**Benefits are available when Covered Services are Medically Necessary.**

The Policy requires the use of Designated Providers for specialized services including, but not limited to Inpatient care in Rehabilitation Facilities. When a Designated Provider doesn't perform these services, we won't pay benefits.

For a complete Summary of Benefits, please refer to the *Covered Services* section of the High Deductible Personal BluePlan and to any Endorsements you choose.

**Optional Endorsement**

The following optional benefit is available for an additional premium.

**Optional Maternity Endorsement**

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

We will pay Allowable Charges for a covered pregnancy if: 1) the pregnancy is determined by a Physician to have begun more than 30 days after this optional coverage is purchased; and 2) the pregnancy terminates while the optional endorsement is in force. The period of time is measured from the Effective Date of the optional endorsement.

Benefits are payable based on the length of time the endorsement has been in force at the time the pregnancy terminates and do not apply to the Benefit Period Deductible. Coinsurance amounts paid for maternity services as provided by this optional coverage do not apply to the Out-of-Pocket Expense Limit.

**Maternity Schedule**

Period of Time	Percentage of Allowable Charges Payable
Allowable Charges incurred during the first 12 months the optional endorsement is in force	5%
Allowable Charges incurred from the 13 <sup>th</sup> month through the 24 <sup>th</sup> month the optional endorsement is in force	60%
Allowable Charges incurred from the 25 <sup>th</sup> month through the 36 <sup>th</sup> month the optional endorsement is in force	80%
Allowable Charges incurred from the 37 <sup>th</sup> month and after the optional endorsement is in force	100%

Covered Services only include:

1. Pre-natal services normally associated with a pregnancy. Pre-natal services include the following when Medically Necessary: pre-natal profile; pregnancy test and blood tests including immunoglobulin, hemoglobin and glucose tolerance tests; ultrasound/echography; urinalysis; vaginal culture; chlamydia study; pelvimetry, fetal non-stress or stress tests; rhogam injection and cerclage.
2. Medically Necessary services normally associated with a vaginal delivery, cesarean section or stillbirth after 26 weeks, including the use of pitocin and other labor inducing drugs. Complications of Pregnancy, as defined, are covered under the Policy and not under this Endorsement. Charges incurred due to Complications of Pregnancy will be subject to any Policy Deductible, Rate of Payment provisions and all other Policy provisions.
3. Routine newborn nursery care from the moment of birth until the child is discharged from the Hospital.

The following are not covered:

1. Charges for educational materials.
2. Charges for infertility diagnosis and treatment, including but not limited to drugs, artificial insemination, in-vitro fertilization, surrogate pregnancy, fees associated with sperm banking or reversal of sterilization.

### **Exclusions and Limitations of the Policy**

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

1. Treatment provided in a government Hospital that you 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 or benefits (whether or not you have applied for such payment or benefits) under any motor vehicle no-fault law;
3. Injuries or diseases paid by Workers' Compensation 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 Covered Person's immediate family; and for services for which a charge is normally not made in the absence of insurance;
5. Cosmetic Surgery: Cosmetic Surgery does not include reconstructive Surgery when service is incidental to or following Surgery resulting from trauma, infection or other diseases of the involved part, except as allowed in the Policy, or reconstructive Surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect;
6. Illness contracted or injury sustained as the result of: war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or an auxiliary unit;
7. Rest cures and Custodial Care;
8. Transportation, except as shown in *Covered Services*;
9. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. This exclusion does not include corrective Surgery or treatment for metabolic or peripheral vascular disease;
10. Dental care or treatment, except as shown in *Covered Services*;
11. Eyeglasses, contact lenses (except after cataract Surgery) and hearing aids and examinations for their prescribing or fitting;
12. Normal pregnancy or childbirth, except as provided when the Optional Maternity Endorsement is purchased. Your Schedule Page will show if you have purchased the Optional Maternity Endorsement;
13. Treatment, services or supplies received as a result of suicide, attempted suicide or intentionally self-inflicted injuries whether the patient was sane or insane;
14. Services, care or supplies used to detect and correct, by manual or mechanical means, structural imbalance, distortion or subluxation in your body for purpose of removing nerve interference and its effects when this interference is the result of or related to distortion, misalignment or subluxation of, or in, the spinal column;

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

### **Pre-existing Conditions**

Services or supplies for Pre-existing Conditions aren't covered until the patient has been insured for 12 months under this Policy. A Pre-existing Condition is a condition:

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

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

Pre-existing Conditions don't include congenital anomalies of a covered Dependent child.

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

### **Individual Transfer Right**

If you buy an individual accident, health or accident and health insurance policy, you 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 of transfer. Any special provision excluding coverage for a specified condition may remain after the transfer, and any waiting period or Pre-existing Condition limitation period specified in the Policy to which transfer is made may be required to be served after the transfer.

### **About Premiums**

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

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

For information about premiums, please see page 1 of the Personal BluePlan High Deductible.

### **Extension of Benefits After Termination of Coverage**

In the event your Policy isn't renewed, we may extend coverage if you or your covered Dependents are in the Hospital or if you or your covered Dependents are Totally Disabled when coverage under this Policy ends.

We'll extend benefits until one of these events occurs: 1) the date the hospitalization ends or the date of recovery from the Total Disability; or 2) all benefits are used; or 3) 12 months from the termination date. 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 Covered Person isn't able 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 isn't able to perform the usual and customary activities of a child in good health of the same age and sex.

**Important Note:** You must notify us if you wish to exercise the Extension of Benefits rights by contacting the Claims Service Center. In order for us to recognize Extension of Benefits and ensure proper payment, each claim must be accompanied by a Physician's statement of disability and be approved by our medical personnel.

## **Renewability Provision**

You may renew the Policy on any premium due date by paying the required premium on or before the due date and within the grace period. We may nonrenew the Policy:

1. If you don't pay the premiums according to the terms of the Policy or we have not received timely premium payments; or
2. If you commit fraud or intentionally misrepresent a material fact under the terms of the Policy; or
3. If we decide to discontinue offering the Personal BluePlan High Deductible for everyone who has it. However, we may only discontinue coverage if we:
  - a. Provide notice to each individual covered by the Policy of the discontinuance at least 90 days before the date the Policy is discontinued;
  - b. Offer to each individual covered by the Policy, the option to buy 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 offering the option to purchase other individual coverage.
4. At the time of renewal, we may modify the Policy for everyone who has it as long as the modification is consistent with state law and effective on a uniform basis.

However, we won't decline to renew your Policy simply because your physical or mental health or your insured Dependents' physical or mental health changes.