

## 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)

COLUMBIA, SC 29219

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

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### PERSONAL BLUE<sup>SM</sup> BASIC LIMITED BENEFITS HEALTH INSURANCE COVERAGE POLICY FORM NO. 13036M OUTLINE OF COVERAGE

#### Read Your Policy Carefully

This Outline of Coverage briefly describes the important features of the Personal Blue Basic Policy. 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 coverage to persons insured 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, Copayments 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 that preauthorizes behavioral health benefits. MRIs, MRAs, CT Scans and PET Scans performed in an Outpatient Facility or a Physician's office require Preauthorization by National Imaging Associates. 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 services.

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

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

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

If you don't use an In-network Provider, it's your responsibility to contact us before receiving services and 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 no benefits will be paid.**

#### Benefit Description

You may choose from the following Plans:

## Single Coverage

Copayments					Deductible In-Network / Out-of-Network	Benefit Percentage In-Network / Out-of-Network	Out-of-Pocket Maximum In-Network / Out-of-Network
Primary Care Physician	Specialist	Emergency Room	Outpatient Care	Inpatient			
\$15	\$25	\$150	\$200	\$300	\$500 / \$1,500	60/40	\$5,000 / \$10,000
\$15	\$25	\$150	\$200	\$300	\$1,000 / \$3,000	60/40	\$5,000 / \$10,000
\$15	\$25	\$150	\$200	\$300	\$1,500 / \$4,500	60/40	\$6,000 / \$12,000
Deductible / Coinsurance	Deductible / Coinsurance	\$150	\$200	\$300	\$5,000 / \$10,000	70/50	Unlimited

## Family Coverage

Copayments					Deductible In-Network / Out-of-Network	Benefit Percentage In-Network / Out-of-Network	Out-of-Pocket Maximum In-Network / Out-of-Network
Primary Care Physician	Specialist	Emergency Room	Outpatient Care	Inpatient			
\$15	\$25	\$150	\$200	\$300	\$1,500 / \$4,500	60/40	\$10,000 / \$20,000
\$15	\$25	\$150	\$200	\$300	\$3,000 / \$9,000	60/40	\$10,000 / \$20,000
\$15	\$25	\$150	\$200	\$300	\$4,500 / \$13,500	60/40	\$12,000 / \$24,000
Deductible / Coinsurance	Deductible / Coinsurance	\$150	\$200	\$300	\$10,000 / \$20,000	70/50	Unlimited

### Deductible – You Pay

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

### Benefit Percentage – We Pay

The amount we pay after applicable Deductibles and Copayments have been met.

### Copayments – You Pay

Copayments for Primary Care Physicians and Specialists are In-network only. Copayments for Emergency Room, Outpatient Care and Inpatient Admissions are In-Network and Out-of-Network.

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

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

### Out-of-pocket Maximum – You Pay

For a single Policy, Covered Services will be paid at 100% of the Allowable Charges when a Member reaches his or her Out-of-pocket Maximum. For a family Policy, Covered Services will be paid at 100% of the Allowable Charges when the family reaches the family Out-of-pocket Maximum. However, the Covered Services for Mental Health Services and/or Substance Abuse Care and Maternity care (if purchased), **won't be increased to 100%. If you choose a plan that has an unlimited Out-of-pocket maximum, covered services will not 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, Coinsurance amount for maternity when purchased; charges in excess of the Allowable Charge; amounts exceeding any Maximum Payments for benefits; or any expense not allowed according to any provisions of this Policy.

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.

<b>Benefit Period Maximum Payment – We Pay</b> (All Benefit Period Maximums are per Member Per Benefit Period)	<p>\$2,500 Skilled Nursing Facility Services</p> <p>\$10,000 Inpatient Rehabilitation</p> <p>\$500 Short-Term Therapy Physical Services</p> <p>\$2,500 Durable Medical Equipment</p> <p>\$1,500 Orthotic/Ostomy combined Inpatient and Outpatient</p> <p>\$1,000 per Tooth not to exceed \$3,000 for Dental Services related to Accidental Injury</p> <p>\$2,000 for Mental Health Services and/or Substance Abuse Care (combined Inpatient, Outpatient, Physician and Prescription Drugs, In-network and Out-of-Network).</p> <p>\$10,000 Home Health Care and Hospice Care (combined).</p>
<b>Lifetime Maximum Payment – We pay</b> Per Member	<p>\$2,000,000 includes \$100,000 Inpatient Rehabilitation, specified amounts for Human Organ and/or Tissue Transplants and \$10,000 Mental Health Services and/or Substance Abuse Care (combined Inpatient, Outpatient, Physician and Prescription Drugs, In-network and Out-of-Network).</p> <p><b>Transplant Lifetime Maximum</b></p> <ul style="list-style-type: none"> <li>• Kidney (single/double) \$60,000</li> <li>• Pancreas and Kidney \$150,000</li> <li>• Heart \$120,000</li> <li>• Lung (single/double) \$150,000</li> <li>• Liver \$200,000</li> <li>• Pancreas \$80,000</li> <li>• Heart and (single/double) Lung \$200,000</li> <li>• Bone Marrow \$200,000</li> </ul>

**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; chemotherapy; inhalation therapy; physical therapy; radiation therapy.
Physician Services	Surgery; administration of anesthesia; daily Hospital medical care; Outpatient services; treatment of accidents; non-routine office visits.
Therapy Services	When Medically Necessary and ordered by a Physician.
Preventive Benefits	<p><u>Preventive Office Visit Charge</u> – 100% after Copayment. This is coverage for the office visit charge only.</p> <p><u>Preventive Pap Smear Screening</u> – 100% of Allowable Charges. Benefits are limited to one per Benefit Period for any Member, or more often if recommended by a medical doctor. An In-network Provider must provide the services.</p> <p><u>Preventive Prostate Screening and Laboratory Work</u> – 100% of Allowable Charges when performed according to the most recently published guidelines of the American Cancer Society. An In-network Provider must provide the services.</p> <p><u>Preventive Mammography</u> – 100% of Allowable Charges for any Member according to the most recently published guidelines of the American Cancer Society. A Contracting Mammography Provider must provide the services.</p> <p><u>Preventive Colorectal Screening and Testing</u> – Paid at the In-network or Out-of-network percentage of Allowable Charges after the Deductible when performed according to the most recently published guidelines of the American Cancer Society.</p>
Home Health Care	Medically Necessary services when ordered by a Physician.

Hospice Care	Medically Necessary services when ordered by a Physician and when the patient is diagnosed with less than six months to live.
Other Covered Services	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.
Prescription Drugs	<p>We will cover only 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>Benefits will not be provided or paid for the following: 1) service charge or handling fee for a Prescription Drug; 2) more than the number of days supply shown in Optional Prescription Drug Coverage; 3) Prescription refills in excess of the number specified or refills dispensed more than one year after the original prescription date; 4) Prescription Drugs for Pre-existing Conditions and/or Ridederred conditions; or 5) Prescription Drugs that are not Medically Necessary.</p> <p>Prescription Drugs received from a Contracting Pharmacy – Benefits will be based on the option you choose.</p> <p>Prescription Drugs received from a Non-Contracting Pharmacy – Benefits will be based on the option you choose.</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</p> <ul style="list-style-type: none"> <li>Specialty Drug Network Providers – Benefits will be based on the option you choose.</li> <li>All other Pharmacy Providers – No Benefits</li> </ul> <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: 1) service charge or handling fee for a Specialty Drug; 2) more than the number of days supply shown in Optional Prescription Drug Coverage; 3) Prescription refills in excess of the number specified or refills dispensed more than one year after the original prescription date; 4) Specialty Drugs for Pre-existing Conditions and/or Ridederred conditions; or 5) Specialty Drugs that are not Medically Necessary.</p> <p>Specialty Drug coverage is not available with the Generic Card option.</p>
The BlueCard Program	<p>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. The Blue Cross and Blue Shield Plan where you are treated is the “Host Plan.”</p> <p>Whenever you receive healthcare services through BlueCard outside our service area, the amount you pay for Covered Services is calculated on the <b>lower</b> of:</p> <ul style="list-style-type: none"> <li>• The billed charges for your Covered Services; or</li> <li>• The negotiated price that the Host Blue Cross and/or Blue Shield Plan passes on to us.</li> </ul> <p>Blue Cross and Blue Shield of South Carolina is the entity with which you have the policy. 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.</p>

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 health care services according to the applicable statute in effect when you received care.

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

For a complete Summary of Benefits, please refer to the *Covered Services* section of the Personal Blue Basic Policy.

**Optional Coverage**

The following Prescription Drug options are available. You must choose one prescription drug option. Benefits are provided per prescription or refill.

Special Drugs, if included in the drug option you choose, are covered only when purchased from a Specialty Drug Network Provider. For Specialty Drugs, Network Pharmacy refers to the Specialty Drug Network Providers. Non-Participating Network Pharmacies include all Providers for Specialty Drugs.

<b>Option</b>	<b>Mail Service Pharmacy</b>	<b>Network Pharmacy</b>	<b>Non-Participating Network Pharmacy</b>
<b>Blue Rx<sup>SM</sup></b> Generic, Preferred and Non-Preferred Drugs Specialty Drugs	Payable at the In-network percentage after the Deductible. Benefits are limited to a 90-day supply.	Payable at the In-network percentage after the Deductible. Benefits are limited to a 31-day supply. 100% after you pay the Specialty Drug Copayment of: 10% not to exceed \$200	Payable at the Out-of-network percentage after the Deductible. Benefits are limited to a 31-day supply. No Benefits
If a Physician prescribes a Brand-name Drug for a specific medical reason and dispense as written, then benefits are payable as indicated above. If a Physician allows the substitution of a Brand-name Drug and the Member still requests the Brand-name Drug, then benefits are payable as indicated above and the Member must pay any difference between the cost of a Generic Drug and the higher cost of a Brand-name Drug.			
<b>Drug Card</b>	Benefits are limited to a 90-day supply.	Benefits are limited to a 31-day supply or a 90-day supply with 3 Prescription Drug Copayments.	Benefits are limited to a 31-day supply or a 90-day supply with 3 Prescription Drug Copayments.
Generic	100% after you pay the Prescription Drug Copayment of: \$16	100% after you pay the Prescription Drug Copayment of: \$8 including designated Over-the-counter Drugs	Payable at the Out-of-network percentage after you pay the Prescription Drug Copayment of: \$8 including designated Over-the-counter Drugs
Preferred	\$70	\$30	\$30
Non-Preferred Drugs	\$140	\$60	\$60
Specialty Drugs		10% not to exceed \$200	No Benefits
If a Physician prescribes a Brand-name Drug for a specific medical reason and dispense as written, then benefits are payable at 100% 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.			

Option	Mail Service Pharmacy	Network Pharmacy	Non-Participating Network Pharmacy
<b>Secure Card</b>	Benefits are limited to a 90-day supply.	Benefits are limited to a 31-day supply or a 90-day supply with 3 Prescription Drug Copayments.	No Benefits
Generic	100% after you pay the Prescription Drug Copayment of: \$25	100% after you pay the Prescription Drug Copayment of: \$10 including designated Over-the-counter Drugs	
Preferred	\$115	\$45	
Non-Preferred Drugs	\$190	\$75	
Specialty Drugs		20% of Allowable Charges.	No Benefits
If a Physician prescribes a Brand-name Drug and there is an equivalent Generic Drug available (whether or not the Physician marks 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.			
<b>Generic Card (Generics Only)</b>	Benefits are limited to a 90-day supply.	Benefits are limited to a 31-day supply or a 90-day supply with 3 Prescription Drug Copayments.	No Benefits
	100% 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% after you pay the Prescription Drug Copayment of: \$10 for Generic and designated Over-the-counter Drugs and Diabetic Brand-name Drugs when there is no Generic Drug equivalent (single source Brand-name Drug)	
Specialty Drug		No Benefits	No Benefits
<b>Basic Card</b>	Benefits are limited to a 90-day supply.	Benefits are limited to a 31-day supply or a 90-day supply with 3 Prescription Drug Copayments.	No Benefits
Generic	100% after you pay the Prescription Drug Copayment of: \$25	100% after you pay the Prescription Drug Copayment of: \$15 including designated Over-the-counter Drugs	
Preferred	\$115	\$60	
Non-Preferred Drugs	\$190	\$75	
Specialty Drugs		50% of Allowable Charges	No Benefits
If a Member requests a Brand-name Drug (whether or not the Physician marks dispense as written) and that drug has a generic equivalent, then the Member will pay 100% of the cost for that drug.			

The following optional benefits are available at an additional premium.

### Dental and Vision Coverage

**Dental Benefits** – 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 each Member each Benefit Period. All covered dental services apply to the \$300 maximum payment.

<u>Covered Service</u>	<u>Percentage of Allowable Charges Payable</u>
Class 1	100%
Class 2, except for removal of impacted teeth	50%

### Vision Benefits

\$100 for eye exam per Member per Benefit Period.

\$50 for frames, lenses and/or contact lenses (combined) per Member per Benefit Period.

### **Supplemental Accident**

This optional coverage provides benefits at 100% of Allowable Charges for the first \$500 for Covered Services incurred by you due to accidental injury. Any amounts over \$500 are payable under the regular Policy benefits and are subject to the Deductible and Coinsurance.

Benefits under the Supplemental Accident coverage are limited to \$500 per Member per Benefit Period.

### **Optional Maternity**

Optional Maternity is only available to you or your covered spouse. No coverage is available for dependent children.

Benefits for pregnancy are payable at the percentage below. Pregnancy benefits, as provided in this optional benefit, are subject to the Policy's Pre-existing Condition Limitation.

<b>Maternity Schedule</b>	<b>Percentage of Allowable Charges Payable</b>
Period of Time	
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 delivery services normally associated with a vaginal delivery, including the use of pitocin and other labor inducing drugs and stillbirth after 26 weeks.

Prescription pre-natal vitamins are only covered if the maternity option is chosen.

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

### **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 are not legally responsible for; or for which benefits are provided under Medicare or other governmental programs (except Medicaid).
2. Any charges for services or supplies for which you are entitled to payment or benefits (whether or not you have applied for such payment or benefits) under any motor vehicle no-fault law.
3. Injuries or diseases paid by Workers' Compensation (if a Workers' Compensation claim is settled, then we'll consider it paid by Workers' Compensation).
4. Separate charges for services provided by employees of Hospitals, laboratories or other institutions; for services or supplies performed or furnished by a member of the Member'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 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 does not include corrective Surgery or treatment for metabolic or peripheral vascular disease.
11. Dental care or treatment, except as shown in *Covered Services*. However, removal of impacted teeth are never covered.
12. Eyeglasses (except as shown in *Covered Services*), contact lenses (except after cataract Surgery) and hearing aids and examinations for their prescribing or fitting.
13. Normal pregnancy or childbirth, except as provided when the Optional Maternity coverage is purchased. Your application and the Schedule of Benefits of the Policy will show if you purchased the Optional Maternity coverage.
14. Treatment, services or supplies received as a result of suicide, attempted suicide or intentionally self-inflicted injuries whether the patient was sane or insane.
15. Services, care or supplies used to detect and correct, by manual or mechanical means structural imbalance, distortion or subluxation in your body for purpose of removing nerve interference and its effects when this interference is the result of or related to distortion, misalignment or subluxation of, or in, the spinal column;

### **Pre-Existing Conditions**

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

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

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

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

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

Listing the names of your Physicians and 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.

### **Individual Transfer Right**

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

### **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 Blue Basic 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 is Totally Disabled on the day coverage ends. The Member's coverage will continue while the Member remains Totally Disabled from the same or related cause until one of these occurs: 1) the date the hospitalization ends or the date of recovery from the Total Disability, whichever is later; or 2) the Policy maximums are met; or 3) 12 months from the termination date. We will pay benefits only for Covered Services as listed in the 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:** You should notify us if you wish to exercise the Extension of Benefits rights. In order for us to recognize Extension of Benefits and ensure proper payment, claims must be accompanied by a Physician's statement of disability.

### **Renewability Provision**

You may renew the 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 we have not received timely premium payments; or.
2. If you commit fraud, make a false statement or omission or misrepresent a fact, whether intentional or not, in the application which was material to us in deciding to issue the Policy; or
3. If we decide to discontinue offering the Personal Blue Basic Policy for everyone who has it. However, coverage may only be discontinued if we:
  - a. Provide notice to each individual covered by the Personal Blue Basic Policy of the discontinuance at least 90 days before the date the Policy is discontinued;
  - b. Offer to each individual covered by the Personal Blue Basic Policy, the option to purchase other individual Health Insurance coverage currently offered by us; and
  - c. Act uniformly without regard to any Health Status-related Factor of enrolled individuals or individuals who may become eligible for coverage in exercising the option to discontinue the Policy or offering the option to purchase other individual coverage.
4. At the time of renewal, we may modify the Personal Blue Basic Policy for everyone who has it as long as the modification is consistent with state law and effective on a uniform basis.

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