THE MARK IV

COMPREHENSIVE MAJOR MEDICAL EXPENSE COVERAGE

Your Right to Examine This Policy

The Mark IV is a health insurance contract. When you get it, you have 10 days to examine it, your application, and any amendments, riders or endorsements to the contract.
Read the contract carefully. If you're not happy with it, you may return it within 10 days to Blue Cross and Blue Shield of South Carolina or to its agent with a note that says you don't want it. If you do that, any premiums you have paid will be returned to you.

Policy: When it's Valid

It takes three things to put this contract into effect. The first is your application. The second is your first payment. The third is for your application to be accepted by the Company – Blue Cross and Blue Shield of South Carolina. The contract goes into effect on the date your application is accepted by the Company.
With this contract, you become a member of Blue Cross and Blue Shield of South Carolina, which is a mutual insurance company. As a member, you – the policyholder – have the right to vote at the Annual Meeting of Members. This meeting is held at the Blue Cross and Blue Shield of South Carolina each year on the 3rd Thursday of April at 11:00 a.m., eastern standard time. You remain a member of Blue Cross and Blue Shield of South Carolina for as long as this contract is in force.
This policy, your enclosed application and ID card, and any amendments, riders or endorsements make up the whole contract between you and the Company. No change in this contract is valid unless it comes to you as an amendment, rider or endorsement signed by an officer of the Company. No agent has the authority to change this contract or to waive any of its provisions.

Renewal At The Option of Blue Cross and Blue Shield of South Carolina As Stated

The Company has the option not to renew this contract, for the reason stated below.
If the Company finds that you are overinsured in accordance with its standards on file with the South Carolina Department of Insurance, it may decline to renew your contract the next time your premium is due. The Company may also decline to renew your policy if it declines to renew the Mark IV for everyone who has this form. If the Company does not renew the Mark IV for everyone who has it, the Company may offer to replace everyone's policy with a new policy form, or, the Company may amend the Mark IV for everyone who has it.
However, the Company will not decline to renew your contract simply because of a change in your physical or mental health or any changes in the physical or mental health of any of your insured dependents.
You will receive 31 days written notice if the Company doesn't renew your policy.

About Premiums

The current premiums charged for each attained age group eligible for this contract are shown on the premium rate sheet that is included with this contract. The Company has the right to change this table of premiums on a class basis. If this table of premiums changes, you will be notified at least 31 days in advance of the date that the change affects you.
Note that your premium also changes as you enter an older attained age group.
You pay premiums each month or every three months. If premiums change, you pay the new rates the next time your premium is due.

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA

M. Edward Seller
President

Important
You will receive maximum benefits under Mark IV if you get approval from Blue Cross and Blue Shield of South Carolina for inpatient hospital and skilled nursing facility admissions. The amount you have to pay for inpatient hospital and skilled nursing facility admissions will increase if you don't receive approval.

ENDORSEMENT TO THE MARK IV POLICY
(Policy Form Number 11159)

Subject to all provisions of the Mark IV Policy except as specified below, this Endorsement is a part of the Mark IV Policy.

Deductibles and Out-of-Pocket Expense Maximums

Under the Mark IV Policy, you choose the deductible amount. You may choose from the deductible amounts listed below or from those shown on page 2 off the Mark IV Policy. The Out-of-Pocket Expense Maximum for each deductible amount is also listed below.

Deductible	Out-of-Pocket Expense Maximum
$ 500	$1,000
$ 750	$1,000
$1,000	$1,000
$1,500	$1,000
$2,000	$1,000
$2,500	$1,000

The deductible amount you chose is shown on your application, which is part of your policy.

You deductible does not apply toward your Out-of-Pocket Expense Maximum.

South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

M. Edward Sellers
President and Chief Operating Officer

MARK IV
HEALTH COVERAGE

The "General Information" section follows on page 6 of this policy. It tells you how you get approval from Blue cross and Blue Shield of South Carolina for medically necessary hospital and skilled nursing facility admissions.

SUMMARY OF BENEFITS

How Benefits Are Paid

Each benefit period (except for inpatient psychiatric expenses), when a person insured by this policy has covered medical expenses, the Company pays 80% of the allowable charge for those expenses that are more than the deductible amount, until the Out-of-Pocket Expense Maximum for that insured person has been satisfied. After that, the Company will pay 100% of the allowable charge for covered medical expenses for the rest of the benefit period for that person (except for hospital and skilled nursing admissions without the required approvals – see page 6 & 7).

Inpatient Psychiatric Benefits

This contract pays 50% of the allowable charge for covered expenses up to a maximum payment of $5,000 in benefits for covered inpatient psychiatric care (hospital and doctor charges combined) in a lifetime for each insured person. Psychiatric care means treatment of mental or nervous conditions and detoxification treatment for drug addiction or alcoholism, but psychiatric care does not include rehabilitative care needed because of abuse of drugs, alcohol or other substances. Covered expenses not paid by the Mark IV for inpatient psychiatric care do not contribute toward your Out-of-Pocket Expense Maximum.

Maximum Benefits

The Mark IV pays up to $1,000,000 in benefits in a lifetime for each insured person ($5,000 lifetime maximum for inpatient psychiatric care).

Deductible

$250, $500 or $1,000. The deductible amount you choose is shown on your application which is part of your contract. (For more information see "Deductible" page 5).

Out-of-Pocket Expense Maximum

DEDUCTIBLE	OUT-OF-POCKET EXPENSE MAXIMUM
$ 250	$1,000
$ 500	$2,500
$1,000	$2,500

Your Out-of-Pocket Expense Maximum amount can be found on your application which is part of your contract. Your deductible does not apply toward your Out-of-Pocket Expense Maximum. (For more information see "Out-of-Pocket Expenses page 5).

OBSTETRICAL SERVICES

Complications of Pregnancy

Benefits are payable for any female under single or family coverage for covered expenses attributable to com-plications of pregnancy. The following are examples of such complications.

1. Post partum hemorrhage; severe toxemia;
2. Rupture or prolapse of the uterus;
3. Non-elective caesarean section;
4. Ectopic pregnancy which is terminated;
5. Spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible; and
6. Similar severe medical and surgical conditions.

Optional Routine Obstetrical Coverage

If you have optional routine obstetrical coverage, it will show on your application which is part of your contract. Under this coverage benefits are not payable for dependent children. Benefits are provided only for a wife under family coverage or a female policyholder.

After you have served your waiting periods, the following amounts are payable for optional routine obstetrical services. These amounts are for combined hospital and doctor covered charges:

- During your first year of coverage, up to $1,000.
- During your second year of coverage, up to $1,500.
- During your third year and each year after that, up to $2,000.

There are no additional benefits due under your major medical expense coverage.

For both kinds of obstetrical coverage (if you have both) benefits are still payable, if the Company declines to renew the contract (as explained on the first page of this policy), if obstetrical services would have been covered had the contract remained in force.

Be sure to read the "Waiting Periods" section of this contract for more information about obstetrical services.

Optional Waiver of Deductible for Accident Related Services

You may choose coverage which does not have the deductible amount taken for covered hospital and medical-surgical charges relating to an accident. This mean that covered charges for services or supplies relating to an accident and received within 90 days of the accident will be paid at the percentage specified in the "Summary of Benefits" on page 2 whether or not you have met the deductible amount. If you have this optional waiver deductible, it will be shown on your application, which is part of your contract.

COVERED MEDICAL EXPENSES

IMPORTANT: Hospital and Skilled Nursing Facility admissions require approval from Blue Cross (see the "General Information" section on page 6 of this policy).

Covered Inpatient Hospital Expenses

- Semiprivate room or special care unit (burn, heart or intensive care). The covered expense for a special care unit is up to 14 days per admission. For services received after 14 days, benefits for covered expenses will be paid at the semiprivate room rate.
- Operating and recovery rooms.
- Anesthetics.
- X-ray and lab services.
- Prescribed drugs.
- Blood and blood plasma.
- Other prescribed hospital supplies and services.
- Services in a skilled nursing home (SNF) when you are admitted within 14 days after being discharged from a hospital. The SNF must have a written contract with a Blue Cross Plan.

Covered Outpatient Hospital Expenses

- Treatment of an accident, including lab and x-ray services.
- Surgery, including lab and x-ray services.
- Physical, radiation and inhalation therapy and chemotherapy.
- Diagnostic lab and x-ray services.

Covered Doctor Expenses

- Treatment of an accident, including lab and x-ray services.
- Inpatient surgery.
- Outpatient surgery, including lab and x-ray services.
- Assistance at surgery by another doctor, when the operation is complicated enough to cause the need for an assistant, if an intern or resident is not available. Payment is up to 20% of the benefit paid for surgery.
- Obstetrical services for complications of pregnancy for any female covered under this contract.
- Anesthesia administration when done by a doctor who did not do the surgery or deliver a baby.
- Hospital and SNF medical (not related to surgery) visits, limited to one visit a day.
- Consultations in a hospital, limited to one consultation during an admission.
- Intensive care in a hospital.
- Psychotherapy and electroshock therapy when the patient is in a hospital.
- Home and office visits that are not part of routine physical exams.

Other Covered Expenses

- Medical supplies, insulin, and drugs that require a prescription from a doctor before they can be sold.
- Ambulance service to or from the nearest local hospital.
- Outpatient services by a licensed, professional physical therapist.
- Prosthetic appliances, if they are needed and prescribed because of an illness or injury that occurred after the effective date of a person's coverage under the contract.
- Oxygen and the rental of equipment for using oxygen outside of a hospital or skilled nursing home.
- Private duty nursing services in the home by a graduate professional registered nurse (R.N.), up to a maximum payment of $500 each benefit period for each insured person.
- Orthopedic lifts, braces and crutches.
- Prescribed durable medical equipment, including such items as special beds, wheelchairs, iron lungs and kidney dialysis machines – monthly rental costs for these items are covered, up to the purchase price.
- Diagnostic lab and x-ray services.

Waiting Periods

After the effective date of a person's coverage under this contract, there are some waiting periods before benefits will be paid:

- 6 months for removal of tonsils and adenoids, and varicose veins.
- 6 months for treatment of hernias.
- 6 months for treatment of hemorrhoids.
- 6 months for disorders of the reproductive systems.
- 6 months for tubal ligations and vasectomies.

These waiting periods do not apply in case of an emergency if there is no previous medical history of the condition prior to the effective date of the person's coverage.

Under this contract, routine obstetrical coverage is optional. You do not automatically get it. If you purchase optional routine obstetrical coverage, services are not covered unless the expected date of delivery is at least 270 days later than the effective date of coverage under this contract. For routine obstetrical services, benefits and provided only for a female policyholder or wife under family coverage.

DEFINITIONS AND RELATED COVERAGE REQUIREMENTS

Here are words and terms you need to know to help you understand your health insurance.

Allowable charge: benefits for covered medical expenses, except for hospital and skilled nursing homes, are based on the allowable charge for a service or supply. Allowable charges are reviewed and updated once during each calendar year. Blue Cross and Blue Shield of South Carolina arrives at the allowable charge by considering the charges made during the prior calendar year by all physicians or suppliers who perform the same service, economic factors, and the lowest charge for similar services and supplies generally available.

Benefits for covered medical expenses for hospitals and skilled nursing homes are based on a hospital's or skilled nursing home's actual charges.

Benefit period: a benefit period begins on the effective date of your coverage under this policy and lasts for 365 day. Then a new benefit period begins.

Conversion privilege: major changes in your life, such as marriage, death or divorce, can cause changes in your health insurance. If a major change happens, let the company know as soon as you can so that the proper changes can be made to provide continuous insurance for all persons covered under this policy or to provide for new family members.

If you get a divorce and your spouse wants his or her own policy, he or she must apply within 60 days from the final decree of divorce. When we receive the application, we will issue a Mark IV Policy for your former spouse. All probationary and waiting periods will be met to the extent coverage was in force under this policy.

If you marry and you want to switch from single to family coverage, you should apply immediately. If your application is received within 60 days after the date of the marriage, and is accepted, your family coverage will be effective from the date of your wedding.

When your children cease to be your dependents (as defined below), they can get their own coverage by applying for it within 60 days.

If you – the policyholder – die and have family coverage in force, your family can continue insurance under this contract simply by applying and paying the premiums. Or, any surviving dependents can buy their own contract. To do either of these things, they must apply within 60 days after your death.

Deductible: People covered by this contract have a deductible amount. The policyholder chooses the amount of the deductible. This means that the Company will not pay any part of covered medical expenses that go toward the deductible each benefit period for each insured person. The deductible you choose is shown on your application which is part of your contract.

Doctor: a doctor is a medical doctor, an oral surgeon, a podiatrist, or osteopath who is licensed to perform a service covered under this contract.

Family Coverage: health insurance for the policyholder and for each dependent for whom specific written application for coverage has been approved by the Company.

"Dependent" means the policyholder's husband or wife and the policyholder's unmarried children under age19, or under 23 years of age if the child is a full-time student, including a natural child, adopted child, stepchild or foster child dependent upon the policyholder for at least 51 percent of support.

An insured dependent shall cease to be covered under this policy as of the first premium due date following his or her failure to qualify under the above definition of dependent.

The policyholder shall give the Company prompt, written notice of such changes in insured dependents so that a premium adjustment can be made. **Coverage of Newborn Children –** For a policyholder with family coverage, coverage for newborn children is provided for 31 days after the date of birth for treatment of sickness or injury. To provide continued coverage for a newborn child beyond that 31 day period, you must apply to the Company and pay the required premium within 31 days from the date of birth. To provide coverage for a newborn child for a policyholder with single coverage, you must apply to the Company and pay the required premium. The application is subject to health underwriting by the Company.

Hospital: a hospital is one of the following, if it is licensed as a hospital in the state in which it is operated:

1. A short term, acute care general hospital.
2. A short term, acute care children's hospital.
3. A short term, acute care maternity hospital.
4. A short term, acute care eye, ear, nose and throat hospital.
5. A private psychiatric hospital accredited by the Joint Commission on Accreditation of Hospitals (JCAH).
6. A hospital operated by the State of South Carolina that has a written agreement with the Company.

A hospital is not a place for rest, the aged, any type of rehabilitative care, custodial care or intermediate care. Benefits will not be paid under this contract for service in any of these places.

ID card: you will get a Blue Cross and Blue Shield ID card with your contract. It will show if you have single or family coverage.

Incapacitated dependent children: the age limit for dependent children does not apply to an unmarried child who is incapable of self-support because of a mental or physical handicap.

To keep coverage for an incapacitated child after age 19 or 23 (so long as this contract is still in force), the Company must receive written proof of the disability in writing from a medical doctor (M.D.) no later than 31 days after the 19th or 23rd birthday. If the Company decides that the child is incapacitated, based on the medical doctor's documentation, written documentation must be furnished to the Company each year, within 31 days of the child's birthday.

Medically necessary: benefits are payable for services or supplies that are medically necessary. Medically necessary means that a service or supply is required to identify or treat the injury or illness that a doctor has diagnosed or reasonably suspects. The service or supply must be consistent with proper diagnosis or treatment, conform to standards of good medical practice, be performed in the least costly setting allowed by the patient's condition, and must not be performed simply for the convenience of the patient or the doctor. The simple fact that a doctor has performed or prescribed something does not mean it is medically necessary.

Obstetrical services: any service or treatment related to or arising from the state of pregnancy.

Out-of-Pocket expenses: covered medical expenses not eligible for reimbursement under this policy, but do not include any deductible amounts. Covered expenses not paid by your Mark IV for inpatient psychiatric care do not contribute toward your Out-of-Pocket Expense Maximum.

Single coverage: health insurance only for the policyholder.

Skilled nursing home (SNF): a skilled nursing home must be licensed as a skilled nursing facility in the state in which it operates, it must have 24-hour a day nursing services by or under the supervision of registered graduate professional nurses (R.N.), it must provide skilled nursing are under the supervision of a licensed medical doctor (M.D.).

Surgery rules: the allowance payable for surgery includes payment for pre- and post-operative care.

If two or more operations take place at the same time through the same opening, the allowable charge is covered for the major operation and no benefit is paid for the smaller operation. But if two or more operations take place as the same time, through different openings, the allowable charge is covered for the major operation and 50% of the allowable charge is covered for each other operation.

When more than one skin lesion is removed at one time, the allowable charge is covered for the biggest lesion, 50% of the allowable change is covered for the removal of the second largest lesion, and 25% of the allowable charge is covered for removing any other lesions.

Cosmetic Surgery Rule – In the case of cosmetic or plastic surgery, your doctor must write to the Company in advance for written approval for benefits to be paid. Benefits are not always paid for this kind of surgery and you need to know that before you have it. Benefits are paid for reconstructive surgery that is medically necessary because of our following surgery resulting from trauma, infection or other diseases of the involved part. Benefits are also paid for medically necessary reconstructive surgery because of a functional birth defect of a dependent child. In order for benefits to be paid, the patient must have been continuously insured by this or another contract (a contract that provides coverage for this kind of surgery) issued by the Company at the time the accident happened, when the disease or infection occurred, or when the dependent child was born.

Surgical assistant: a doctor who helps the operating physician when complicated surgery is performed in a hospital and when such help is not available by an intern, resident or house physician.

Termination provision – Extension of Benefits after termination of coverage: If the Company does not renew your contract except for overinsurance, and you (or any member of your family who is covered under this contract) are in the hospital or continuously disabled when your coverage under this contract ends, benefits will be paid while the insured patient remains continuously disabled for the same or related cause. This payment will continue until the insured patient:

- Uses up all of his or her benefits, or
- Has received benefits for up to 365 days for covered services, whichever occurs first.

GENERAL INFORMATION

APPROVAL FROM BLUE CROSS

So that the highest possible allowance is paid for medically necessary admissions, Blue Cross must give approval for hospital admissions and skilled nursing facility admissions in advance.

There are three kinds of approval: Pre-Admission Review, Emergency Review and Continued Stay Review.
They are explained below.

Pre-Admission Review

You must get Pre-Admission Review approval before you or your dependents are admitted to a hospital or skilled nursing home (SNF). If you don't call for approval, or if the admission is disapproved but you go anyway, here's how benefits will be paid:

- No benefits will be paid for any part of room and board charges
- 80% of the allowable charges will be paid for all other covered hospital SNF expenses (50% of the allowable charge for psychiatric care admissions).

Emergency Admission Review

When you have an emergency (a life threatening situation), Blue Cross doesn't expect you to wait for Pre-Admission Review approval before you go to the hospital.

However, except for reasons beyond your control, you must notify Blue Cross a follows:

- Within 24 hours after the emergency admission, or
- By 5 p.m. of the next working day following a weekend or holiday (Monday following a weekend or the day after a holiday if it's a working day).

If you don't call for approval except for reason beyond your control, here's how benefits will be paid:

- No benefits will be paid for any part of room and board charges
- 80% of the allowable charge will be paid for all other covered hospital expenses (50% of the allowable charge for psychiatric care admissions).

Continued Stay Review

If you need to be in the hospital longer than Blue Cross gave approval for, you must call Blue Cross for **Continued Stay Review**. You and the doctor will be notified by the HCMS nurse as to whether the continued stay is approved and for how long. If it is not approved and you stay in the hospital, or if you don't call for approval, here's how benefits will be paid:

- No benefits will be paid for any part of hospital room and board charges for the continued stay.
- 80% of the allowable charge will be paid for other covered hospital expenses (50% of the allowable charge for psychiatric care admissions).

Getting in Touch With Blue Cross

To contact Blue Cross for approval, call one of these toll-free numbers:

- 1-800-327-3238 in South Carolina.
- 1-800-334-7287 from outside South Carolina

When you call Blue Cross, you'll talk with a nurse in the Health Cost Management Services (HCMS) department. She'll ask you for the following information:

1) Policyholder's name and ID number,
2) Patient's name and relationship to the policyholder,
3) Doctor's name, address and phone number,
4) Hospital's or skilled nursing home's name, address and phone number,
5) The reason you need the medical care.

The nurse will let you, the doctor and the hospital know whether the medical care is approved.

If you or your dependent can't call Blue Cross for approval, a relative or friend may call for you. Whoever calls should be able to give HCMS the necessary information. Be sure to call one of the numbers given above. Don't call any of the customer service numbers given in this Policy. Customer service personnel can't give approval for medical care.

Reminder

You are responsible for getting your own approvals.

SERVICES AND SUPPLIES THAT ARE NOT COVERED

Some services and supplies you may get will not be covered under this contract. Benefits for the following will not be paid:

- Room and board charges in any hospital or skilled nursing facility, when the required approvals were not obtained as stated on page 6 and 7 of this policy.
- Services or supplies that are not medically necessary.
- Services or supplies not performed or prescribed by a doctor.
- Inpatient medical care by more than one doctor a day.
- Medical care by a doctor on the same day or during the same hospital admission during which you have surgery, unless a medical specialist is needed for a condition the surgeon couldn't treat.
- Outpatient psychiatric care, including care for mental or nervous disorders, drug addiction or alcoholism.
- Routine obstetrical services unless you elected to take the Optional Routine Obstetrical Coverage. See page 3 for benefits.
- Routine physical exams, hospital nursery charges and the first medical exam of a newborn well baby, well baby care, and immunizations.
- Surgery just to make you look better (usually called cosmetic or plastic surgery), unless it is cosmetic reconstructive surgery that is medically necessary because of or following surgery resulting from trauma, infection or other diseases of the involved part or because of a functional birth defect. See "Surgery Rules" in this contract for more information about this kind of surgery.
- Treatment or tests as an inpatient that could have been done as an outpatient.
- Custodial or intermediate care. This is care meant simply to help people who cannot take care of themselves.
- Acupuncture or sex change procedures.

- Treatment for obesity or weight reduction.
- Gastric bypass or stapling, intestinal bypass, and any related procedures including complications resulting from the procedures, or the reversal of the procedures.
- Experimental surgery or services such as, but not limited to, biofeedback, wiring the teeth or gums together for the purpose of losing weight, hyperthermia, hypnosis, test tube babies, artificial insemination and laetrile therapy.
- Hospital charges for dental treatment – unless the patient must be in the hospital for dental services because of a medical problem, such as a severe heart condition.
- Doctors' dental services, including fixing the mouth for dentures, removing impacted teeth, and services or supplies for temporomandibular joint dysfunctions.
- Services by a psychologist, social worker or relative.
- Computerized axial tomography (CAT) scans, except for the following:
    1) Those performed on a machine operated by a hospital and approved by health planning authorities designated by Public Law 93-641,
    2) Those performed by providers who have a written agreement with the corporation to perform computerized axial tomography (CAT) scans in their offices.
    3) Payment for supervision and professional interpretation of computerized axial tomography (CAT) scans.
- Services or supplies for which you are not legally obligated to pay.
- Treatment of illness or injury resulting from acts of war or military services.
- Services you are not charged for in VA hospitals or other kinds of hospitals or agencies.
- Services or supplies made necessary by perpetration by an insured person of an assault or active participation in a felony or riot.
- Injury or disease covered by Workers' Compensation. If Workers' Compensation claim in settled, it will be considered covered by Workers' Compensation.
- Services or supplies payable by Medicare, Workers' Compensation, or any other government or private program (except for Medicaid or similar program).
- Educational, occupational, rehabilitative, recreational or speech therapy.
- Inpatient admissions, or portions of admissions, for physical therapy.
- Any type of rehabilitative care, including that for alcohol, drug or other substance abuse.
- Eyeglasses, contact lenses except after cataract surgery, hearing aids, and examinations for their fitting.
- Prescribed drugs you take home from a doctor's office, hospital or skilled nursing home.
- Appliances, bandages, devices, sundries, birth control medication, and non-prescription drugs.
- Services, supplies or treatment that began before you has coverage under this contract or that you receive after you are no longer insured under this contract, except for coverage, if any, provided for the "Termination Provision," which is explained on page 6.
- Travel, luxury or convenience items, even if recommended by a doctor.
- Hospitalization primarily for diagnostic purposes.
- Psychiatric care when the patient is in a facility that doesn't meet the definition of hospital given in this contract.
- Private duty nursing services in a hospital or skilled nursing facility by licensed practical nurses, licensed registered nurses, sitters or companions.
- Services or care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or sublaxation in the human body for purposes of removing nerve interference and the effects of such nerve interference, where such interference is the result of or related to distortion, misalignment or sublaxation of, or in, the vertebral column.
- Anesthesiology by the doctor who performs the patient's surgery or who delivers a baby.
- Reversal of tubal ligations and vasectomies.

- **Pre-existing Condition Limitation**

  Services or supplies for pre-existing conditions are not covered until the patient has been insured for 12 months under this policy. A pre-existing condition is a condition misrepresented or not revealed in the application and for which symptoms existed before the effective date of coverage under this contract which would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice or treatment was recommended by or received from a doctor.

GENERAL POLICY PROVISIONS

1. Entire Contract; Changes

The policy, your enclosed application and ID card, and any amendments, riders or endorsements make up the whole contract between you and the Company. No change in this contract is valid unless it comes to you as an amendment, rider or endorsement signed by an officer of the Company. No agent has the authority to change this contract or to waive any of its provisions.

2. Time Limit on Certain Defenses

It is possible to make a mistake in filling out an application for an insurance contract. During the first two years this contract is in force, the Company cannot deny a claim because of an error in the application, unless you error misled the Company about the risk it assumed when the application was accepted. If it is found that your error on the application was misleading in this manner, the Company may have grounds to void the policy, in which case your premiums will be refunded, minus any benefits paid for your claims you or your dependents have had.

After the contract has been in force for two years, the Company cannot deny a claim because of an error in your application unless you made deliberate misstatements in an effort to deceive the Company. If the contract is declared void for this reason, your premiums will be refunded, minus any benefits paid for claims for you and your dependents.

No claim for loss incurred or disability, as defined in the policy, commencing after one year from the date of issue of this policy, shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

3. Grace Period

Unless the Company has notified you of its intent not to renew this contract, the following information about the grace period applies to this contract.

If you do not pay your premium by the date it is due, the Company gives you a grace period. If you are paying your premiums monthly, the grace period is 10 days. If you are paying every three months, the grace period is 31 days. In either case, this contract remains in force during the grace period.

However, the Company is entitled to the premium due during the grace period and may collect any unpaid premium by deducting it from any claims payment due to you. If you do not pay your premium by the end of the grace period, you have cancelled you contract as of the end of the grace period.

4. Reinstatement

Blue Cross and Blue Shield of South Carolina may reinstate this contract, as its option, if you ask for reinstatement after your coverage has lapsed because you didn't pay your premium. You should ask for reinstatement by writing the Customer Service Center.

No agent has the authority to accept a premium for reinstatement or to reinstate this contract. If reinstatement is approved by the Company, this contract will be reinstated as of the date it lapsed. You should receive written notice from the Company about approval or disapproval of your request. If you don't get a written notice of disapproval by the 45th day after you request reinstatement, your coverage is automatically reinstated. The Company will charge a fee for reinstatement.

5. How to File Claims; Notice and Proof of Loss

Show your ID card when you get health care services or supplies, so that people who file claims for you can see the information on it. However, if you have to file your claims, get an itemized bill for the services or supplies and attach it to a Comprehensive Major Medical claim form.

You can get the form from the Blue Cross and Blue Shield Customer Service Center. The address and phone numbers for the Customer Service Center are given in the section of this contract called "How to Get Help From Blue Cross and Blue Shield of South Carolina."

The back of the claim form gives you instructions on how it should be filled out. Attach your itemized bill to the form and mail it to the following address:

Comprehensive Claims Department
Blue Cross and Blue Shield of South Carolina
Drawer F
Columbia, SC 29260.

You can use this claim form for all covered medical expenses you get, but there is a special drug claim form you can use. This drug claim form should be mailed to the address shown on the special drug claim form.

An itemized bill or receipt you send when you file your own claims must have the following information on it:

1. The name of the doctor, hospital, drug store, etc.,
2. The patient's name and date of birth
3. Your name (you are the insured person),
4. Your ID number,
5. The date the illness or injury began,
6. The date of service,
7. The name of the service,
8. The charge for the service, and
9. The name of the illness or injury.

Except in the absence of legal capacity, claims must be received by the end of the calendar year after the year in which you received services or supplies in order for claims to be paid.

6. Payment of Claims

All benefits provided in this contract will be paid promptly upon receipt of due proof of loss. In the absence of assignment of benefits to the provider of services, payments shall, at the option of the Corporation, be made either directly to the policyholder or the provider of the service.

7. Physical Examinations

The Company may require a physical exam, at its expense, or any insured person as often as is reasonable to settle claims.

8. Legal Actions

No action at law or equity can be brought against the company until 60 days after a claim (notice and proof of loss) has been received. No such action can be brought against the Company more than six years after a claim was received.

9. Conformity with State Statutes

Any provision of this contract which, on its effective date, is in conflict with the statutes of the state in which policyholder lives on such date, is hereby amended to conform with the minimum requirements of such statutes.

10. Non-Assessable

This is non-assessable contract. You – the policyholder – are not subject to any assessment for any contingent liability. This means that if, for any reason, the Company owes money, you are not responsible for paying it.

11. Other Valid Coverage: Proration

This contract is not meant to duplicate other valid coverage you have with other insurance policies. "Other Valid Coverage" is defined as health insurance coverage that is similar to the coverage provided by this contact, 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 this Company.

If you have other valid coverage and Blue Cross and Blue Shield of South Carolina has not been notified of this coverage by you in writing, the Company will "prorate" benefit payments when your claim is received.

The Company will carefully consider all of the valid health insurance that covers your claims and claims for your dependents. Then, the Company will determine its responsibility for your loss in proportion to the responsibility that should be accepted by other insurance companies. The Company will pay the portion of your claim it is responsible for.

If your claim is prorated, you will receive a refund of the portion of the premiums you have paid for coverage that the Company did not accept as its responsibility. This refund will be based on premiums paid during the time both policies were in effect.

12. Subrogation Rights

Blue Cross and Blue Shield of South Carolina – the Company – is subrogated to your rights against anyone causing you injury, to the extent of benefits paid. This means that if someone causes you to be injured and the Company pays your medical bills, it has the right to get the money back from the person responsible for your injury or from you if they have paid it to you. If you sue the responsible person or if you accept settlement from the person, the Company still has the right to get the money back. And the Company can get the money back from benefits available to you under uninsured motorists provisions of automobile insurance contracts. As a member of Blue Cross and Blue Shield of South Carolina, you should help the Company recover this money, at no expense to you.

HOW TO GET HELP FROM BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA

If you change your address or need information about your health insurance, call the Customer Service Center:

From Columbia, dial 788-0500, ext. 41000 for claims and ext. 42757 for Membership Billing.
From anywhere in South Carolina, dial 1-800-868-2500, toll-free.

If you can't call, write to the following address:

Individual Products
Blue Cross and Blue Shield of South Carolina
P.O. Box 61153
Columbia, SC 29260-1153

Be sure to put your ID number in your letter, along with your name, address and telephone number and the patient's name.

ENDORSEMENT TO THE MARK IV POLICY
(Policy Form Number 11159)

Subject to all provisions of The Mark IV Policy except as specified below, this Endorsement is a part of The Mark IV Policy.

Preferred Advantage (Preferred Personal Care) 80/60 Coverage

If you chose Preferred Advantage 80/60 Coverage, it will be shown on your application, which is part of your contract.

With Preferred Advantage 80/60 Coverage, benefits for covered services will be paid at the percentages shown in the section of this Endorsement called "How Benefits Will Be Paid With Preferred Advantage 80/60 Coverage." A higher percentage is paid on covered services when you or your dependent receives services from Preferred Personal Care (PPC) Providers.

PPC providers are Hospitals, Skilled Nursing Facilities (SNF), Doctors and other health care providers that have a written agreement with Blue Cross and Blue Shield of South Carolina to do the following:

- File all claims for covered services for patients with PPC coverage to Blue Cross and Blue Shield of South Carolina.
- Obtain all required approvals from Blue Cross and Blue Shield of South Carolina.
- For patients with PPC coverage, charge no more than the Blue Cross PPC Allowance.
- Ask patients with PPC coverage to pay only deductibles, copayments, and coinsurance on covered services.

Providers who do not have a written agreement with Blue Cross and Blue Shield of South Carolina to are called "All Other Providers." When care is rendered by an All Other Provider (except a Non-Contracting Facility), the Company will pay benefits based upon the percentage of Covered Expenses indicated in this Endorsement.

You can find out if providers are part of the PPC network by asking them before you or your dependent receive services or supplies.

Be sure to present your Blue Cross Identification Card when you or your dependent receive services or supplies. PPC Providers will know that you have PPC coverage and how benefits will be paid.

Non-Contracting Facilities

No benefits are payable for services or supplies rendered by a Non-Contracting Facility, except for Emergency Services as set forth below and services rendered by Non-Contracting Facilities located outside of the State of South Carolina. "Facility" means a Hospital, Skilled Nursing Facility, Ambulatory Surgical Center, or Clinic. "Contracting Facility" means a Facility with which the Company has a written Contracting Provider Agreement.

Emergency Services By Non-Contracting Facilities

Emergency Services provided by other than a Contracting Facility must be for conditions determined by the Corporation to be Medically Necessary to prevent death, permanent disability, or serious medical complications, or it must be determined by the Corporation that the member had no control over the administration of Emergency Care.

Coverage for Emergency Services continues only so long as the state of Emergency exists, as determined by the Corporation. Any follow-up care must be provided by a Contracting Facility for services to be covered.

If any Emergency occurs and an inpatient Admission is Medically Necessary, the Corporation must be notified within twenty-four hours or the next working day, whichever is later.

Deductibles and Out-Of-Pocket Expense Maximums

Under this Endorsement to the Mark IV Policy, you choose the deductible amount. You may choose from the deductible amounts listed below. The Out-of-Pocket Expense Maximum for each deductible amount is listed also.

Deductible	**PPC Provider**	**Out-of-Pocket Expense Maximum All Other Providers (Except Non-Contracting Facilities)**
$ 250	$1,500	$2,500
$ 250	$5,000	$7,500
$ 500	$1,500	$2,500
$ 500	$5,000	$7,500
$ 750	$1,500	$2,500
$ 750	$5,000	$7,500
$1,000	$1,500	$2,500
$1,000	$5,000	$7,500
$1,500	$1,500	$2,500
$1,500	$5,000	$7,500
$2,000	$1,500	$2,500
$2,000	$5,000	$7,500
$2,500	$1,500	$2,500
$2,500	$5,000	$7,500

Coinsurance on claims for covered services will apply to the Out-Of-Pocket Expense Maximum except coinsurance for psychiatric care. Deductibles, copayments and non-covered expenses will not apply to the Out-Of-Pocket Expense Maximum.

When an insured person's Out-Of-Pocket Expenses reach the PPC maximum amount during a benefit period, covered medical or surgical care by PPC Providers will be paid at 100% of the PPC Allowance for the rest of the benefit period.

When an insured person's Out-Of-Pocket Expenses reach the All Other Providers maximum amount (except Non-Contracting Facilities) during a benefit period, covered medical or surgical care by All Other Providers (except Non-Contracting Facilities), will be paid at 100% of Allowable Charges for the rest of the benefit period.

The percentage paid for psychiatric care will not increase even when the Out-Of-Pocket Expense Maximum is reached.

Except psychiatric care, total Out-Of-Pocket Expenses for each insured person will not exceed the All Other Providers maximum amount during a benefit period.

How Benefits Will Be Paid With Preferred Advantage 80/60 Coverage

All Hospital and Skilled Nursing Facility (SNF) Admissions must be approved by Blue Cross and Blue Shield of South Carolina in order for maximum benefits to be provided.

Without approval, benefits will be reduced or not paid at all. This means that you will have to pay more when approval is not obtained.

Please read carefully the section of this Endorsement called "Approval For Services With Preferred Advantage 80/60 Coverage." It explains how to get approval for services from Blue Cross.

Preferred Advantage 80/60 Coverage provides the benefits listed below for covered services.

Medical or Surgical Care

- For covered services by a PPC Provider, the policy will pay 80% of the PPC Allowance after the deductible is met.
- For covered services by All Other Providers (except Non-Contracting Facilities), the policy will pay 60% of Allowable Charges after the deductible is met. In addition, a $200 copayment will apply to each Admission to All Other Hospitals or Skilled Nursing Facilities (SNF) (except Non-Contracting Facilities).
- The deductible and $200 copayment will not apply to the Out-Of-Pocket Expense Maximum.
- Coinsurance on claims for covered medical or surgical care will apply to the Out-Of-Pocket Expense Maximum.

Inpatient Psychiatric Care

- For covered services by a PPC Provider, the policy will pay 80% of the PPC Allowance after the deductible is met.

- For covered services from All Other Providers (except Non-Contracting Facilities), the policy will pay 60% of Allowable Charges after the deductible is met. In addition, a $200 copayment will apply to each Admission to All Other Hospitals or Skilled Nursing Facilities (SNF) (except Non-Contracting Facilities).

- Benefits for psychiatric care are limited to $5,000 (combined Hospital and Doctor covered charges) in a lifetime for each insured person.

- The deductible and $200 copayment will not apply to the Out-Of-Pocket Expense Maximum.

- Coinsurance on claims for inpatient psychiatric care will not apply to the Out-Of-Pocket Expense Maximum.

- As explained on page 2 of The Mark IV Policy, this policy covers inpatient psychiatric care for treatment of mental and nervous conditions, and detoxification treatment for drug addiction or alcoholism. The policy does not cover rehabilitation care needed because of abuse of drugs, alcohol or other substances.

Prescription Drugs

Preferred Advantage 80/60 Coverage provides benefits for Prescription Drugs and Medical Supplies purchased from a Pharmacy. The Prescription Drugs must be dispensed by a licensed, registered pharmacist.

"Prescription Drugs", "Medical Supplies", and "Pharmacy" mean the following:

> "Prescription Drugs" include insulin and drugs or medications that must be labeled "Caution: Federal law prohibits dispensing without a prescription."
>
> "Medical Supplies" are syringes and related supplies for conditions such as diabetes, dressings for burns and conditions such as cancer, catheters, ostomy bags and related supplies, test tape, surgical trays, and renal dialysis supplies.
>
> "Pharmacy" means a commercial establishment where the Pharmacy profession is practiced, except Doctors' offices and Pharmacies associated with Hospitals, Skilled Nursing Facilities, and similar institutions.

Blue Cross and Blue Shield of South Carolina has entered into an agreement with a network of Pharmacies to provide Prescription Drugs and certain Medical Supplies to members at less than the normal retail price. These Pharmacies are called "Participating Network Pharmacies."

Pharmacies that are not part of the network (Non-Participating Pharmacies) can charge you more than the Allowable Charge. And benefits for drugs and supplies purchased from Non-Participating Pharmacies will be paid at a lower percentage.

When you buy drugs or supplies from a Participating Network 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 or supplies.

Whether you buy drugs or supplies from a Participating or Non-Participating Pharmacy, you must pay the Pharmacy at that time. To file your claim for Prescription Drugs or supplies:

- Use a Blue Rx claim form. You can get these forms by calling or writing the Customer Service Center.
- Fill out the top half of the form, sign it, and attach the receipt for the prescription or supply.
- Mail the form to the Participating Pharmacy Headquarters at the address shown on the form.

Any benefits due will be paid directly to the policyholder. Benefits may not be assigned to or paid directly to the Pharmacy.

Preferred Advantage 80/60 Coverage will provide the following benefits for Prescription Drugs and Medical Supplies upon receipt of a properly completed claim form:

- 80% of Allowable Charges as determined by Blue Cross subject to the deductible when purchased at a Participating Network Pharmacy.

- 60% of Allowable Charges as determined by Blue Cross subject to the deductible when purchased at a Non-Participating Network Pharmacy.

Benefits will not be provided for the following:

- More than a 34 consecutive day supply of Prescription Drugs dispensed by prescription except 100 unit doses of thyroid products, nitroglycerin, digitalis leaf and alkaloids.

- Prescription drug refills more than one year from the original prescription date.

- Any type of service charge including the administration or injection of a prescription drug.

- Prescription Drugs used for weight control, obesity, cosmetic purposes, smoking cessation, hair growth, fertility, or birth control.

- Devices of any type even when dispensed by prescription. Such devices include, but are not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices.

- More than the recommended daily dosage of any prescription drug as described in the current "Physician's Desk Reference."

Approval For Services With Preferred Advantage 80/60 Coverage

Blue Cross and Blue Shield of South Carolina must give advance approval for Admissions to Hospitals and Skilled Nursing Facilities (SNF) in order for maximum benefits to be provided for Medically Necessary Admissions.

If your Doctor recommends hospitalization for you or your dependent, make sure you tell the Doctor that your policy requires approval for all Admissions.

If you or your dependent is admitted to a PPC Hospital or SNF, the PPC Hospital or SNF will call Blue Cross for approval.

If you or your dependent is admitted to an All Other Hospital or SNF (except a Non-Contracting Facility, you are responsible for calling Blue Cross for approval. Remember, Non-Contracting Facilities are not covered, except for Emergency Services and services of Non-Contracting Facilities located outside the State of South Carolina.

Where To Call For Approval

To contact Blue Cross for approval, call the Health Cost Management Services (HCMS) Department at one of these toll-free numbers:

In South Carolina:	1-800-327-3238
Outside South Carolina:	1-800-334-7287

These toll-free numbers are also shown on the front of your Blue Cross Identification Card.

When you call for approval, you will talk with a nurse in HCMS. The nurse will ask you for the following information:

- Policyholder's name and Identification Number
- Patient's name and relationship to the policyholder
- Doctor's name, address, and phone number
- Hospital or SNF's name, address, and phone number
- The reason the patient needs care.

The HCMS nurse will let the Doctor and Hospital know whether the Admission is approved.

If you cannot call Blue Cross for approval, a relative or friend may call for you. The person who calls should be able to give the necessary information to the HCMS nurse.

If you need approval for Admissions, be sure to call HCMS. Please do not call the Customer Service Center. Customer Service personnel cannot give approval for Admissions.

Important

Approval from HCMS means that an Admission is Medically Necessary for treatment of the patient's condition. HCMS approval is not a guarantee or verification of benefits, patient eligibility or payment. Payment of benefits is subject to patient eligibility, waiting periods and any other policy limitations and exclusions.

Types of Approval

There are three types of approval: Preadmission Review, Emergency Admission Review and Continued Stay Review. Each type of approval is explained below.

Preadmission Review

Preadmission Review approval must be obtained before you or your dependent is admitted to a Hospital or SNF. Approval is also needed within 24 hours of the mother's discharge if a newborn is sick and must remain in the Hospital.

If approval is not obtained, or if the Admission is not approved but you or your dependent are still admitted,

- No benefits will be paid for any part of the room and board expenses. However, a PPC Hospital or SNF cannot bill you for room and board charges if it fails to get approval.
- Benefits for covered expenses except room and board will be paid as explained in the section of this Endorsement called "How Benefits Will Be Paid With Preferred Advantage 80/60 Coverage."

Emergency Admission Review

When you or your dependent has an Emergency (a life-threatening situation), Blue Cross does not expect you to wait for Preadmission Review approval before you go to the Hospital.

However, except for reasons beyond your control, Blue Cross must be notified as follows:

- Within 24 hours after the Emergency Admission, or
- By 5 p.m. of the next working day following a weekend or holiday (Monday following a weekend or the first working day after a holiday).

If Emergency Admission Review approval is not obtained, except for reasons beyond your control,

- No benefits will be paid for any part of the room and board expenses. However, a PPC Hospital or SNF cannot bill you for room and board charges if it fails to get approval.
- Benefits for covered expenses except room and board will be paid as explained in the section of this Endorsement called "How Benefits Will Be Paid With Preferred Advantage 80/60 Coverage."

Continued Stay Review

If you or your dependent needs to be in the Hospital for a longer period than that approved by Blue Cross, Continued Stay Review approval must be obtained from HCMS. The HCMS nurse will let the Doctor know whether the continued stay is approved and for how long. If Continued Stay Review is not obtained, or if the continued stay is not approved but you or your dependent stays in the Hospital,

- No benefits will be paid for any part of the room and board expenses for the period of continued stay. However, a PPC Hospital or SNF cannot bill you for these expenses if it fails to get Continued Stay Review approval.
- Benefits for covered expenses except room and board will be paid as explained in the section of this Endorsement called "How Benefits Will Be Paid With Preferred Advantage 80/60 Coverage."

EXCLUSIONS

Benefits will not be paid under Preferred Advantage 80/60 Coverage for the services and supplies listed below. Other exclusions and limitations listed in the section "Services And Supplies That Are Not Covered" on pages 7-9 of The Mark IV Policy also apply to Preferred Advantage 80/60 Coverage.

- No benefits are payable for services or supplies rendered by a Non-Contracting Facility except for Emergency Services and services of a Non-Contracting Facility located outside of the State of South Carolina.

Claims Filing With Preferred Advantage 80/60 Coverage

If you have Preferred Advantage 80/60 Coverage and use PPC Providers, the PPC Providers will file your claims to Blue Cross and Blue Shield of South Carolina.

If you do not use PPC Providers, you can file your claims to Blue Cross and Blue Shield of South Carolina. Please read the section of the policy called "How To File Claims; Notice and Proof of Loss" on pages 9 and 10 for information on filing claims.

Please read the section of this Endorsement called "Prescription Drugs" for instructions on filing claims for Prescription Drugs and Medical Supplies.

Coverage Of Adopted Children

If the policyholder applies to the Company within 31 days and pays required premiums on a timely basis, coverage may be provided for the following adopted children:

1. A newborn child for whom the policyholder enters a decree of adoption within 31 days after birth.
2. A newborn child for whom the policyholder institutes adoption proceedings within 31 days after birth and has been awarded temporary custody by Family Court.
3. A child other than a newborn for whom the policyholder has been awarded temporary custody, if adoption proceedings have been completed, and a decree of adoption entered into within one year from the institution of proceedings, unless extended by order of the court by reasons of the special needs of the child.

Coverage requirements for adopted children are the same as those for other children as described in the Family Coverage and Coverage of Newborn Children sections on page 5 of The Mark IV Policy.

Individual Transfer Right

Any person purchasing The Mark IV Policy after July 1, 1991, has 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 without having to pass medical underwriting.

Any special provision excluding coverage for a specified condition may remain after the transfer. Any waiting period or pre-existing condition period specified in the policy to which transfer is made may be required to be served after the transfer.

Reminder

If you have Preferred Advantage 80/60 Coverage and use PPC Providers, the PPC Providers will get all necessary approvals for covered services.

If you have Preferred Advantage 80/60 Coverage and do not use PPC Providers, you are responsible for getting approvals from Blue Cross.

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA

M. Edward Sellers

M. Edward Sellers
President

AMENDMENT TO THE MARK IV POLICY
(Policy Form Number 11159)

Subject to all provisions of the Mark IV Policy, the policy is revised as specified below.

The Summary of Benefits is amended by the addition of the following:

Inpatient Rehabilitation Services

The maximum lifetime benefit for inpatient rehabilitation services is $100,000 for each insured person.

Subject to all other provisions of this policy, the policy provides benefits for covered expenses related to inpatient rehabilitation services as follows:

Admissions for inpatient care in Rehabilitation Facilities for participation in a multidisciplinary team-structured rehabilitation program following severe neurologic or physical impairment are available benefits as specified above.

In order for these benefits to be available, the following criteria must be met.

(1) All such admission must be ordered by a physician.

(2) All such admissions require preapproval in writing from Blue Cross.

(3) The documentation that accompanies a request for Pre-Admission Review must contain a detailed patient evaluation from a physician. It must document that to a degree of medical certainty the patient has rehabilitation potential such that there is an expectation that this patient will achieve an ability to provide self care and conduct his or her activities of daily living.

(4) Continuation of benefits will require documentation that the patient is making substantial progress toward established goals, and that there continues to be significant potential for the achievement of the stated goals.

Where to Call for Approval

To contact Blue Cross for approval, call the Health Cost Management Services (HCMS) at one of the following toll-free numbers:

In South Carolina 1-800-327-3238
Outside South Carolina 1-800-334-7287

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA

M. Edward Sellers
President

AMENDMENT TO THE MARK IV POLICY
(POLICY FORM NUMBER 11159)

Subject to all provisions of The Mark IV Policy , the policy is amended as specified below.

The "General Information" section is amended by the addition of the following:

Outpatient Review - You must get Preauthorization Review approval before you or your dependent have any of the following outpatient procedures: all outpatient surgery performed in an outpatient surgical facility or hospital; Magnetic Resonance Imaging (MRI), Lithotripsy, and Gastrointestinal Endoscopies (including Colonoscopy, Sigmoidoscopy, Esophagoscopy, Proctoscopy and Gastroscopy).

If you do not get approval in advance and the services are medically necessary, no benefits will be paid for outpatient surgery performed in an outpatient surgical facility or hospital. And 50% of the Allowable Charge will be paid for the outpatient procedures of Magnetic Resonance Imaging (MRI), Lithotripsy, and Gastrointestinal Endoscopies. If the services are not medically necessary, no benefits are paid whether or not you call for approval.

Where to Call for Approval

To contact Blue Cross for approval, call the Health Cost Management Services (HCMS) at one of the following toll-free numbers:

In South Carolina 1-800-327-3238
Outside South Carolina 1-800-334-7287

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA

M. Edward Sellers
President

AMENDMENT TO THE MARK IV POLICY
(POLICY FORM NUMBER 11159)

The Mark IV policy is revised as follows:

Definitions

The Allowable Charge definition on page 4 of your policy is revised to:

Allowable Charge: Benefits for covered medical expenses are based on the Allowable Charge for a service or supply. Allowable Charges are reviewed and updated once a year. Blue Cross determines the Allowable Charge by reviewing the charges made each year. Allowable Charges are determined by Blue Cross, and will not be less than what is listed below.

> The charges made during the previous year by all physicians or suppliers who perform the same service;
>
> The lowest charge for similar services and supplies;
>
> Allowances agreed on by Contracting Providers and Blue Cross'
>
> A set of allowances established by Blue Cross.

The Summary of Benefits is amended as follows:

Percentage of Covered Expenses 60%
Payable for All Other Providers (except Non-Contracting Facilities)

When care is given by All Other Providers (except Non-Contracting Facilities), Blue Cross will pay benefits based upon the percentage of Covered Expenses indicated above.

Non-Contracting Facilities

No benefits are payable for services or supplies rendered by a Non-Contracting Facility, except for Emergency Services as set forth below and services rendered by Non-Contracting Facilities located outside of the State of South Carolina. "Facility" means a Hospital, Skilled Nursing Facility, Ambulatory Surgical Center, or Clinic. "Contracting Facility" means a Facility with which the Company has a written Contracting Provider Agreement.

Emergency Services By Non-Contracting Facilities

Emergency Services provided by other than a Contracting Facility must be for conditions determined by the Corporation to be Medically Necessary to prevent death, permanent disability, or serious medical complications, or it must be determined by the Corporation that the member had no control over the administration of Emergency Care.

Coverage for Emergency Services continues only so long as the state of Emergency exists, as determined by the Corporation. Any follow-up care must be provided by a Contracting Facility for services to be covered.

If any Emergency occurs and an inpatient Admission is Medically Necessary, the Corporation must be notified within twenty-four hours or the next working day, whichever is later.

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA

M. Edward Sellers
President

AMENDMENT TO THE MARK IV POLICY
(Policy Form Number 11159)

Subject to all provisions of the Mark IV Policy, the policy is revised as specified below.

"DEFINITIONS AND RELATED COVERAGE REQUIREMENTS"

The section of the Mark IV policy called "Definitions and Related Coverage Requirements" is amended by the addition of the following:

"Ambulatory Surgical Center" is licensed Facility which: (1) has permanent Facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis; (2) provides treatment by or under the supervision of Physicians and provides nursing services when the patient is in the Facility; (3) does not provide inpatient accommodations; and (4) is not, other than incidentally, a Facility used as an office or Clinic for the private practice of a Physician.

The Facility must be accredited by: (1) the Accreditation Association for Ambulatory Health Care; or (2) the Joint Commission on the Accreditation of Health Care Organizations; or (3) any other comparable professional organization which has as one of its main purposes the investigation of health care Facilities. With its primary objective being to assure that such Facilities have obtained an acceptable level of competency and quality to be able to serve the health care consumer to the highest degree of care; that such Provider has obtained and maintains all applicable governmental licensing; and that such Provider ascribes to the adopted ethics that apply to such Facilities' discipline of practice and care. However, the Corporation reserves the right to accept or reject the accreditation of such organization described in (3) above in its sole discretion.

Facilities located in South Carolina must also have a written contract with the Corporation based upon the Corporation's determination that a demonstrated need exists for such Facility to complement the services provided by other Contracting Providers.

"Contracting Facility" means a Facility with which the Corporation has a written Contracting Provider Agreement.

"Emergency" means a sudden, unexpected onset of acute sickness or accidental injury of such a nature that the life of the Member could be threatened or permanent disability would result without immediate medical attention.

"Facility" means a Hospital, Skilled Nursing Facility, Ambulatory Surgical Center, or Clinic.

"Preferred Personal Care Facility" means a Facility which has entered into a Preferred Personal Care Provider Agreement with the Corporation, as a Preferred Personal Care Facility.

"Clinic" is a Facility for examination and treatment of ambulant patients who are not hospitalized. The Facility must be accredited by: (1) the Accreditation Association for Ambulatory Health Care; or (2) the Joint Commission on the Accreditation of Health Care Organizations; or (3) any other comparable professional organization which has as one of its main purposes the investigation of health care Facilities. With its primary objective being to assure that such Facilities have obtained an acceptable level of competency and quality to be able to serve the health care consumer to the highest degree of care; that such Provider has obtained and maintains all applicable governmental licensing; and that such Provider ascribes to the adopted ethics that apply to such Facilities' discipline of practice and care. However, the Corporation reserves the right to accept or reject the accreditation of such organization described in (3) above in its sole discretion.

Facilities located in South Carolina must also have a written contract with the Corporation based upon the Corporation's determination that a demonstrated need exists for such Facility to complement the services provided by other Contracting Providers.

"Hospital" means a short-term, acute care (1) general Hospital; (2) children's Hospital; (3) eye, ear, nose and throat Hospital; (4) maternity Hospital; or (5) short-term, acute care psychiatric Hospital; which is licensed by the state in which it operates; and (a) for compensation from its patients; (b) on an inpatient basis is primarily engaged in providing diagnostic and therapeutic Facilities for the medical, surgical, and psychiatric diagnosis and treatment of injured or sick persons; (c) by or under the supervision of a staff of Physicians duly licensed to practice medicine; and (d) which provides continuous 24-hour-a-day services by a licensed, registered graduate nurses physically present and on duty. The term Hospital does not include long-term, chronic care institutions or residential institutions that are a nursing home or place for (a) rest, (b) the aged, (c) the treatment of mental or nervous conditions, drug addiction or alcoholism, or (d) rehabilitative care, whether or not such Facility is affiliated with or a part of a Hospital. The Facility must be accredited by: (1) the Joint Commission on the Accreditation of Health Care Organizations; or (2) any other comparable professional organization which has as one of its main purposes the investigation of health care Facilities. With its primary objective being to assure that such Facilities have obtained an acceptable level of competency and quality to be able to serve the health care consumer to the highest degree of care; that such Provider has obtained and maintains all applicable governmental licensing; and that such Provider ascribes to the adopted ethics that apply to such Facilities' discipline of practice and care. However, the Corporation reserves the right to accept or reject the accreditation of such organization described in its sole discretion.

Facilities located in South Carolina must also have a written contract with the Corporation based upon the Corporation's determination that a demonstrated need exists for such Facility to complement the services provided by other Contracting Providers.

"GENERAL INFORMATION"

The section of the Mark IV Policy called "General Information" is amended by the addition of the following:

EMERGENCY SERVICES BY NON-CONTRACTING FACILITIES

Emergency Services provided by other than a Contracting Facility must be for conditions determined by the Corporation to be Medically Necessary to prevent death, permanent disability, or serious medical complications, or it must be determined by the Corporation that the Member had no control over the administration of Emergency Care.

Coverage for Emergency Services continues only so long as the state of Emergency exists, as determined by the Corporation. Any follow-up care must be provided by a Contracting Facility for services to be covered.

If any Emergency occurs and an inpatient Admission is Medically Necessary, the Corporation must be notified within twenty-four (24) hours or the next working day, whichever is later.

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA
(An Independent Licensee of the Blue Cross and Blue Shield Association)

M. Edward Sellers
President

Blue Cross and Blue Shield of South Carolina
(An Independent Licensee of the Blue Cross and Blue Shield Association)
Columbia, South Carolina 29219

Amendment to the Mark IV
(Policy Form No. 11159)

Subject to all the provisions of the Mark IV, form number 11159, the policy is amended by the addition of the following:

THIS AMENDMENT IS A SUPPLEMENT TO THE POLICY AND IS EFFECTIVE AFTER JUNE 30, 1997.

This policy was prepared in conjunction with and is based upon the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Interim Rules for Health Insurance Portability for individual health plans and are subject to change.

HEALTH COVERAGE PROVISIONS UNDER HIPAA

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

Guaranteed Renewable

Renewable At The Option of Blue Cross and Blue Shield of South Carolina as Stated

has been deleted in its entirety and the following has been added:

GUARANTEED RENEWABLE EXCEPT FOR STATED REASONS
The policyholder may renew this policy on any premium due date by paying the premium required at the time of renewal and within the grace period. Blue Cross and Blue Shield of South Carolina may nonrenew the policy:

1. For failure to pay the premiums in accordance with the terms of the policy or the Company has not received timely payments.
2. For performance of an act or practice that constitutes fraud or an intentional misrepresentation of a material fact under the terms of the policy.
3. If the Company decides to discontinue offering the Mark IV for everyone who has this form. However, coverage may only be discontinued if the Company:
   a. Provide notice to each covered individual provided coverage by the Mark IV of the discontinuance at least 90 days before the date of discontinuance of the policy;
   b. Offer to each individual covered by the Mark IV, the option to purchase other individual Health Insurance coverage currently offered by the Company; 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.

However, the Company 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 of your insured dependents.

DEFINITIONS

The following definitions have been added:

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

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

GENETIC INFORMATION. Information about genes, gene products and inherited characteristics that may derive from the individual or family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

HEALTH STATUS-RELATED FACTOR. Any of the following factors: health status; medical condition, including both physical and mental illnesses; claims experience; receipt of health care; medical history; Genetic Information; evidence of insurability, including conditions arising out of acts of domestic violence; or disability.

WAITING PERIOD. The period that must pass with respect to the policyholder before the policyholder is eligible to be covered for benefits under the terms of the policy. The Waiting Period begins on the day You substantially filled out Your Application and ends on the first day of coverage.

FAMILY COVERAGE.

Has been deleted in its entirety and the following has been added:

Health coverage for the policyholder and for each dependent for whom specific written application for coverage has been approved by Blue Cross.

A dependent is the policyholder's spouse and the policyholder's unmarried children under age 19, or under 23 years of age if the child is a full-time student. This includes a natural or adopted child, stepchild, foster child or a child who is under legal guardianship of the policyholder or any other child residing in the policyholder's household and who qualifies as a dependent of the policyholder or spouse under the United States Revenue Code and federal tax regulations. This also includes any child of a divorcing/divorced policyholder who is recognized under a **qualified medical child support order** (QMCSO) as having a right to enrollment under this health coverage. This means coverage may be provided for dependents of the policyholder through this health coverage even though the policyholder is the noncustodial parent when a qualified medical child support order exists. Once a dependent child has been married, he/she is no longer eligible for coverage even if he/she subsequently becomes unmarried.

An insured dependent will cease to be covered under this policy as of the first premium due date following his or her failure to qualify under the above definition of dependent.

The policyholder will give Blue Cross prompt, written notice of such changes with insured dependents so that a premium adjustment can be done. **Coverage of Newborn Children --** coverage for newborn children is provided for 31 days after the date of birth for Medically Necessary covered services and supplies including necessary care and treatment of a medically diagnosed congenital defect, birth abnormalities or complications arising from a premature birth with the appropriate premium payment. To provide continued coverage for a newborn child beyond that 31-day period, the policyholder must apply to Blue Cross and pay the required premium within 31 days from the date of birth. If the above requirements are not met, coverage for the child will not be continuous coverage beyond the first 31 days after its birth and therefore, be subject to the pre-existing conditions limitation.

Coverage for Adopted Children -- If the policyholder applies to Blue Cross with 31 days and pays the required premiums on a timely basis, coverage may be provided for the following adopted children:

1. Coverage shall be provided from the moment of birth for a child for whom a decree of adoption is entered into by the policyholder within 31 days after the date of the child's birth;
2. Coverage shall be provided from the moment of birth for a child for whom adoption proceedings have been instituted by the policyholder within 31 days after the date of the child's birth and the policyholder have obtained temporary custody; or
3. Other than a newborn, upon temporary custody of the child for one year and may be extended by the court.

If the requirements (1) through (3) are not met, coverage for the child will not be continuous coverage beyond the first 31 days after its adoption and therefore, be subject to the pre-existing conditions limitation.

In all cases, whether it's a birth or adoption (proceeding), the required premium will have to be paid before coverage will become effective. The child will not become covered until we give written notice of approval and Blue Cross receives any required premium.

Waiting Periods

The following has been deleted:

After the effective date of a person's coverage under this policy, there are some waiting periods before benefits will be paid:

- 6 months for removal of tonsils and adenoids, and varicose veins.
- 6 months for treatment of hernias.
- 6 months for treatment of hemorrhoids.
- 6 months for disorders of the reproductive systems.
- 6 months for tubal ligation and vasectomies.

These waiting periods do not apply in case of an emergency if there is no previous medical history of the condition prior to the effective date of the person's coverage.

Pre-existing Condition Limitation

The following paragraph has been added:

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

Optional Routine Obstetrical Coverage

If Routine Obstetrical Coverage has been selected, the following paragraph has been added:

Policy benefits for the hospitalization and attendant professional services of the mother and newborn child or children will be provided for the mother and newborn child or children 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. However, the attending physician, in consultation with the mother, may request additional time for hospitalization or release the mother or newborn child or children prior to the expiration of the time provided above.

Termination provision - Extension of Benefits after termination of coverage

Has been deleted in its entirety and the following has been added:

If the Company does not renew your policy, and you (or any member of your family who is covered under this policy) are in the hospital or continuously disabled when your coverage under this policy ends, benefits will be paid while the insured patient remains continuously disabled for the same or related cause. This payment will continue until the insured patient:

- the date of recovery from total disability; or
- uses up all his or her benefits; or
- has received benefits for up to 365 days for covered services, whichever occurs first.

The term "disabled" means that you are receiving ongoing medical care by a physician and can perform none of the usual and customary duties or activities of a person in good health of the same age and sex. A physician's statement of disability will be required.

Important Note: The policyholder must notify the Company if they wish to exercise the Extension of Liability rights. In order for Blue Cross to recognize extension of benefit claims and ensure proper payment, claims must be accompanied by a Physician's statement of disability. Under extension of benefits, benefits are payable only while the patient is in the hospital or is totally and continuously disabled as explained above and are only payable for services related to the disabling condition.

Other Valid Coverage; Proration

Has been deleted in its entirety and the following has been added:

This policy is not meant to duplicate other valid coverage You have with other health insurance policies. "Other Valid Coverage" is defined as health insurance coverage that is similar to the coverage provided by this policy, coverage provided by hospital or medical service organizations, coverage provided by union welfare plans or employee benefit organizations, but not group or individual health insurance with Us.

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

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

Blue Cross and Blue Shield of South Carolina

Thomas G Faulds

Thomas G. Faulds
President and Chief Operating Officer
Blue Cross and Blue Shield Division

AMENDMENT TO THE MARK IV POLICY
(Policy Form No. 11159)

DIABETES COMPLIANCE AMENDMENT

This Amendment is subject to all the provision of the Mark IV policy, form number 11159, which is not otherwise specified in the provisions of this Amendment.

THIS AMENDMENT IS A SUPPLEMENT TO THE POLICY AND IS EFFECTIVE ON OR AFTER JANUARY 1, 2000.

The following benefit has been added:

COVERED MEDICAL EXPENSES

Covered Doctor Expenses

- Diabetes Mellitus. Equipment, supplies, and outpatient self-management training and education for the treatment of an insured person with diabetes mellitus, if medically necessary, and prescribed by a health care professional legally authorized to prescribe such items by law who demonstrates adherence to minimal standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina. Preauthorization review is required for benefits under this provision. The purpose of the Diabetes Initiative of South Carolina Board is to establish a statewide program of education, surveillance, clinical research and translation of new diabetes treatment methods to serve the needs of South Carolina residents.

  Services and payment for diabetes education programs shall conform to regulations of the Health Care Financing Administration, U.S. Department of Health and Human Services, pursuant to Section 4105 of the Balanced Budget Act of 1997. Diabetes outpatient self-management training and education shall be provided by a registered or licensed health care professional with certification in diabetes by the National Certification Board of Diabetes Educators, or other accredited program approved by the Diabetes Initiative of South Carolina, or by the Diabetes Control Program of the S.C. Department of Health and Environmental Control in order to meet the needs of rural communities wherein certified health care professionals providing this service are not available.

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.

The Effective Date of this Amendment is the Effective Date of the Policy, or the Amendment date, whichever is later.

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

Thomas G. Faulds
President and Chief Operating Officer
Blue Cross and Blue Shield Division

AMENDMENT TO THE MARK IV POLICY
(Policy Form Number 11159)

Subject to all provisions of The Mark IV Policy, the policy is revised as specified below.

The Mark IV Summary of Benefits is amended by the addition of the following:

Physical Therapy

The maximum payment per person per benefit year for covered expenses of a licensed professional physical therapist is $1,000.

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA
(www.SouthCarolinaBlues.com)

Thomas G. Faulds
President and Chief Operating Officer
Blue Cross and Blue Shield Division

AMENDMENT TO THE MARK IV POLICY
(Policy Form No. 12000M)

BlueCard Program Amendment

This Amendment is subject to all provisions of the Mark IV Policy, form number 12000M, which are not otherwise specified in the provisions of this Amendment.

This Amendment is a supplement to the Policy and is effective on or after June 1, 2002.

The Policy is amended by the addition of The "BlueCard Program" under Covered Expenses:

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. The Blue Cross and Blue Shield Plan where you are 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.

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.

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 a 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 state statute in effect when you received care.

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.

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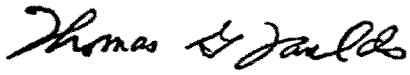

Thomas G. Faulds
President and Chief Operating Officer
Blue Cross and Blue Shield Division

AMENDMENT TO THE MARK IV POLICY
(Policy Form No. 11159)

GRIEVANCE PROCEDURE AMENDMENT

This Amendment is subject to all provisions of the Mark IV Policy, form number 11159, which are not otherwise specified in the provisions of this Amendment.

This Amendment is a supplement to the Policy and is effective on or after January 1, 2002.

The Policy has been revised by the addition of the following section:

GRIEVANCES/APPEALS PROCEDURES

Any complaints or disagreements you have regarding claims for services or benefits may be directed to us at 788-0500, extension 41000 from Columbia, 1-800-868-2500, extension 41000 from anywhere else. You may also send us a secure e-mail through the Ask Customer Service feature of My Insurance Manager on or Web site at www.SouthCarolinaBlues.com.

A preauthorization or preapproval denial for a service or benefit will be considered a denied claim for purposes of this provision. Any complaints or disagreements you have regarding a preauthorization and preapproval may be directed to us at 736-5990 from Columbia or 1-800-327-3238 from anywhere else.

Grievances
If you choose to file a formal grievance, submit it in writing to us at the Claims Service Center, Post Office Box 100300, Columbia, South Carolina 29202. The grievance should include your name, address, Policy number, Social Security number and any other information, documentation or evidence to support your request. Your formal grievance must be submitted within 90 days of the event that resulted in your complaint. We will acknowledge a formal grievance within 10 working days of its receipt. The decision made concerning your formal grievance will be sent to you 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
If you are not satisfied with our decision regarding the grievance, you may request an appeal. You have 30 days after you receive our decision on the formal grievance to request an appeal. Send your request for an appeal to the Claims Service Center, Post Office Box 100300, Columbia, South Carolina 29202. Members on the committee reviewing the appeal will not have previously reviewed the claim.

External Reviews
In certain situations, after you have completed the grievance and appeal process above, you may be entitled to an additional review of your claim at our expense. An external review may be used to reconsider your claim if we have denied it, either in whole or in part. The claim must have been greater than $500 and denied, reduced, or terminated because: 1) it does not meet our requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness; or 2) it is investigational or experimental and it involves a life-threatening or seriously disabling condition.

After your internal appeals are completed, you will be notified in writing of your right to request an external review. You should file a request for external review within 60 days of receiving that notice. You will be required to authorize the release of any medical records that may be needed for the purpose of reaching a decision during the external review. If you need assistance during the external review process, you may contact the South Carolina Department of Insurance for assistance at the following address and telephone number:

South Carolina Department of Insurance
Post Office Box 100105
Columbia, SC 29202-3105
1-800-768-3467

Within 5 business days of your request for an external review, we will respond by either:

1. Assigning your review to an independent review organization and forwarding your records to them; or
2. Telling you in writing that your situation does not meet the requirements for an external review and the reasons for our decision.

The independent review organization will take action on your request for review within 45 days after it receives the request.

Expedited External Reviews

If your doctor 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.

You may also request an expedited review if our denial involves Emergency Medical Care, if you may be held financially responsible and you have not been discharged from the facility.

APPROVAL FOR SERVICES WITH PREFERRED ADVANTAGE 80/60 COVERAGE has been revised by the addition of the following paragraph:

Please note that if your request is denied for preauthorization or preapproval for services or benefits, you may request further review under the guidelines set out in the *Grievances/Appeals Procedures* section of this Policy. Remember that preauthorization and preapproval denials are considered as denied claims for purposes of grievances and appeals.

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.

The Effective Date of this Amendment is the Effective Date of the Policy, or the Amendment date, whichever is later.

BlueCross BlueShield of South Carolina
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(www.SouthCarolinaBlues.com)

Thomas G. Faulds
President and Chief Operating Officer
Blue Cross and Blue Shield Division

AMENDMENT TO THE MARK IV POLICY
(Policy Form No. 11159)

Pharmacy Benefit Manager Amendment

This Amendment is subject to all provisions of the Mark IV Policy, form number 11159, which are not otherwise specified in the provisions of this Amendment.

This Amendment is a supplement to the Policy and is effective on or after November 1, 2003.

***Other Covered Expenses* in the *COVERED MEDICAL EXPENSES* section, is revised by the deletion of the following paragraph:**

The Pharmacy Benefit Manager (PBM) for Blue Cross and some of its subsidiaries contracts with and manages the pharmacy network, negotiates prices with the contracting pharmacies and performs other administrative services. Blue Cross receives a portion of the financial credits from drug manufacturers through the PBM. These credits are based on the total volume of claims processed for preferred drugs utilized by all Blue Cross members, and certain members of plans issued by some of its subsidiaries. Because these credits are based upon volume, neither Blue Cross nor the PBM can relate any one claim to a preferred drug credit. The credits are therefore used to help stabilize overall rates and to offset expenses. Reimbursements to pharmacies, or discounted prices charged at pharmacies, are not affected by these credits. Any coinsurance percentage that you must pay for prescription drugs are based on the allowable charge at the pharmacy, and does not change due to receipt of any preferred drug credit by Blue Cross.

Please substitute the following paragraphs in place of the deleted paragraph:

The Pharmacy Benefit Manager (PBM) for Blue Cross and some of its subsidiaries contracts with and manages the pharmacy network, negotiates prices with the contracting pharmacies and performs other administrative services. Blue Cross receives a portion of the financial credits directly from drug manufacturers and through the PBM. The credits are used to help stabilize overall rates and to offset costs. Reimbursements to pharmacies, or discounted prices charged at pharmacies, are not affected by these credits.

Any coinsurance percentage that you must pay for prescription drugs is based on the allowable charge at the pharmacy, and does not change due to receipt of any financial credit by Blue Cross.

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Thomas G Faulds

Thomas G. Faulds
President and Chief Operating Officer
Blue Cross and Blue Shield Division

AMENDMENT TO THE MARK IV POLICY
(Policy Form No. 11159)

HIPAA AMENDMENT

Subject to all provisions of the Mark IV Policy, form number 11159, the policy is amended by the following:

This Amendment is a supplement to the policy and is effective immediately.

The Definitions section has modified by the revision of the following:

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

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

Individual Membership
Blue Cross and Blue Shield of South Carolina
P.O. Box 61153
Columbia, SC 29260
(803) 264-2757
1-800-868-2500, ext. 42757

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

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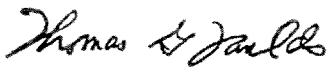


Thomas G. Faulds
President and Chief Operating Officer
Blue Cross and Blue Shield Division

AMENDMENT TO THE MARK IV POLICY
(Policy Form No. 11159)
CORE PLAN II 80 COVERAGE OPTION and
CORE PLAN II 80/60 COVERAGE OPTION
OPTIONAL LIMITED BENEFIT HEALTH COVERAGE

AMENDMENT

This Amendment is subject to all the provisions of The Mark IV Policy, form number 11159, which are not otherwise specified in the provisions of this Amendment.

This Amendment is a supplement to the Policy and is effective on or after November 1, 2009.

The *Definitions and Related Coverage Requirements* section is amended by the revision of the following paragraphs. The revisions should not be construed as a complete replacement of the noted section:

Family coverage: Health coverage for the policyholder and for each dependent for whom specific written application for coverage has been approved by Blue Cross.

A dependent is the policyholder's spouse and the policyholder's unmarried children under age 19, or under 23 years of age if the child is a full-time student. This includes a natural or adopted child, stepchild, foster child or a child who is under legal guardianship of the policyholder or any other child residing in the policyholder's household and who qualifies as a dependent of the policyholder or spouse under the United States revenue Codes and federal tax regulations. This also includes any child of a divorcing/divorced policyholder who is recognized under a **qualified medical child support order** (QMCSO) as having a right to enrollment under this health coverage. Once a dependent child has been married, he or she is no longer eligible for coverage even if he or she subsequently becomes unmarried. A dependent child who is a full-time student on the day prior to beginning a "Medically Necessary Leave of Absence" may remain covered under this health plan until the earlier of: 1) one year from the first day of the medically necessary leave of absence; or 2) the date on which the coverage would otherwise terminate under the terms of the terms of the policy.

A dependent child must enroll as a full-time student the next regular term following the end of a medically necessary leave of absence to remain classified as a full-time student.

An insured dependent shall cease to be covered under this policy as of the first premium due date following his or her failure to qualify under the above definition of dependent.

The policyholder will give Blue Cross prompt, written notice of such changes with insured dependents so that a premium adjustment can be done. **Coverage of Newborn Children** – coverage for newborn children is provided for 31 days after the date of birth for Medically Necessary covered services and supplies including necessary care and treatment of a medically diagnosed congenital defect, birth abnormalities or complications arising from premature birth with the appropriate premium payment. To provide continued coverage for a newborn child beyond that 31-day period, the policyholder must apply to Blue Cross and pay the required premium within 31 days from the date of birth. If the above requirements are not met, coverage for the child will not be continuous coverage beyond the first 31 days after its birth and therefore, be subject to the pre-existing conditions limitation.

Coverage for Adopted Children – If the policyholder applies to Blue Cross with 31 days and pays the required premiums on a timely basis, coverage my be provided for the following adopted children:

1. Coverage shall be provided from the moment of birth for a child for whom a decree of adoption is entered into by the policyholder within 31 days after the date of the child's birth;
2. Coverage shall be provided from the moment of birth for a child for whom adoption proceedings have been instituted by the policyholder within 31 days after the date of the child's birth and the policyholder has obtained temporary custody; or

3. Other than a newborn, upon temporary custody of the child for one year and may be extended by the court.

If the requirements (1) through (3) are not met, coverage for the child will not be continuous coverage beyond the first 31 days after its adoption and therefore, be subject to the pre-existing conditions limitations.

In all cases, whether it's a birth or adoption (proceeding), the required premium will have to be paid before coverage will become effective. The child will not become covered until we give written notice of approval and Blue Cross receives any required premium.

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.

The *Definitions and Related Coverage Requirements* section is amended by the addition of the following definitions:

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.

Medically Necessary Leave of Absence: Occurs when a full-time student stops attending school, or drops to part-time attendance, due to a serious illness or injury that prevents full-time attendance. We must receive documentation from the full-time student's treating physician certifying that he or she is suffering from a serious illness or injury and that the leave of absence is medically necessary.

The *Grievances/Appeals Procedures* section is amended by the deletion of External Reviews and Expedited External Reviews and the following substituted. The revisions should not be construed as a complete replacement of the noted section:

External Reviews

After your internal appeals are completed, you will be notified in writing of your right to request an external review. You should file a request for external review within 60 days 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. The claim in question must be greater than $500 and 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 5 business days of your request for an external review, we will respond by either assigning your 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.

If your request is assigned to an IRO, the IRO will determine within 5 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 7 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, including:

1. A general description of the reason for the request for external review;
2. The date the independent review organization received the request from us;
3. The date the external review was conducted;
4. The date of its decision;
5. The principal reason or reasons for its decision;
6. The rational for its decision;
7. References to evidence or documentation, including the practice guidelines, considered in reaching its decision; and
8. The written opinions of the clinical review panel, if any.

If the IRO's decision is to allow benefits, within 5 business days of our receipt of the notification, we must approve the benefit as covered, subject to applicable policy exclusions, limitations and other provisions.

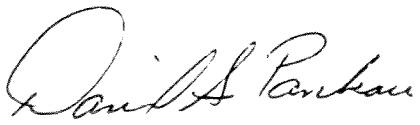
Expedited External Review
You can file a request for an expedited external review within 15 days after receiving a notice of a denied claim if you meet the requirements under Standard Review listed above in paragraph 2 or if the denial concerns an admission, availability of care, continued stay or health 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.

When we receive your request for an expedited external review, we will assign your review to an IRO and forward your 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.

No more than three business days after it receives your request for an expedited external review, the IRO must provide a notice of its decision to you and us. If the IRO's decision is to allow benefits, we must approve the benefit as covered, subject to applicable policy exclusions, limitations and other provisions.

All requests for external review will be at our expense.

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)



David S. Pankau
President and Chief Operating Officer
Blue Cross and Blue Shield of South Carolina

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

(Policy form numbers listed below)

Health Care Reform Amendment

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

12505M-30 Day, 12520M-30 Day, 11183, PCHP; MM-11283 (Rev. 1/93) POL, PCHP COL-11183 (Rev. 1/93) POL, 10003, 10777, New Mark Two; MM-10777 and 11159

BlueCross BlueShield of South Carolina believes this **Policy** is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your **Policy** may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to us at 803-264-6401 or toll-free at 1-800-868-0500, extension 46401.

You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

This Amendment to the Policy is effective on or after the Benefit Period of your Policy starting September 23, 2010.

The Policy is revised as follows:

Dependent Child

The definition of Dependent is revised to the following:

Dependent: Your lawful spouse and children through age 25. 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.

The Policy is further revised to delete all references to Full-time Student and all dependent age references are revised to state through age 25.

Lifetime Maximum

All references to Lifetime Maximums are deleted.

Benefit Period Maximum

In addition to the Benefit Period Maximums shown in your Policy and/or your Schedule of Benefits, your policy will now have a $1,000,000 Benefit Period Maximum for essential health benefits.

Rescission of Coverage

Any references in the policy to coverage being rescinded due to a person misstating the facts on the application for insurance are revised to state the following: Coverage may only be rescinded when the covered person has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material facts related to insurability.

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.

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(www.SouthCarolinasBlues.com)

James A. Deyling
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)