

# 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 3<sup>rd</sup> 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.

<b>Deductible</b>	<b>Out-of-Pocket Expense Maximum</b>
<b>\$ 500</b>	<b>\$1,000</b>
<b>\$ 750</b>	<b>\$1,000</b>
<b>\$1,000</b>	<b>\$1,000</b>
<b>\$1,500</b>	<b>\$1,000</b>
<b>\$2,000</b>	<b>\$1,000</b>
<b>\$2,500</b>	<b>\$1,000</b>

The deductible amount you chose is shown on your application, which is part of your policy. Your deductible does not apply toward your Out-of-Pocket Expense Maximum.



*M. Edward Sellers*

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 complications 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 means 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 are 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 days. 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 age 19, 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 19<sup>th</sup> or 23<sup>rd</sup> 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 care 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 at 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 charge 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 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 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 is 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 subluxation 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 subluxation 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 your 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 45<sup>th</sup> 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 contract, 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.

## 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](mailto: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).

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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)

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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)

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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 đỡ 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)

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

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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 tagasalín, tumawag sa 1-844-389-4839. (Tagalog)

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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)

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إن كان لديك أو لدى شخص تساعد أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية 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)

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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)

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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)

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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)

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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)

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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)

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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)

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اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره ی این برنامه ی 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 شماره ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

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Ni da doodago t'áá háida biká'aná nilwo'ígíí díí Béeso Ách'ááh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'ishíí bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'í' ha desdzih nínízingo, koji' béésh bee hółne' 1-844-516-6328. (Navajo)