GROUP NAME: Greater Columbia

GROUP NUMBER: 05-81785-00

EFFECTIVE DATE: August 1, 2018

PLEASE REPLACE THE

APPROPRIATE PAGES OF YOUR

CONTRACT WITH THE CONTENTS

IN THIS ATTACHMENT.

The holder of this Contract is a member of Blue Cross® and Blue Shield® of South Carolina and is entitled to vote in person or by proxy at any and all meetings of said Corporation. This is a nonassessable contract and the holder is not subject to any contingent liability. The annual meeting of the members shall be held at the Home Office of the Corporation on the third Thursday in April at 11:00 A.M., Eastern Standard Time.

Business Blue℠ Health Insurance Contract

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA

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

(A mutual insurer organized under the Laws of the State of South Carolina and hereinafter referred to as the Corporation)

HOME OFFICE: Columbia, South Carolina 29219

Client No. 36434
and all applicable groups

IN CONSIDERATION

of the Application made by

Greater Columbia

(hereinafter called the Employer)

a copy of which is attached hereto and made part of this Contract, and in consideration of payment by the Employer of the premium as herein provided,

THE CORPORATION HEREBY AGREES TO PROVIDE

the coverage and benefits herein described for a period of one year beginning at 12:01 A.M., on the date indicated below, hereinafter called the Effective Date and from year-to-year thereafter, unless this Contract is terminated as provided herein. The premium shall be due and payable by the Employer in advance of the Effective Date and thereafter as provided herein. This Contract is issued and delivered in the State of South Carolina, is governed by the laws thereof and is subject to the terms and provisions recited over the signatures hereto affixed.

IN WITNESS WHEREOF, THE CORPORATION HAS caused this Contract to be signed this 1st day of August, 2018.

Scott Graves
President
Blue Cross and Blue Shield Division

®Registered Marks of the Blue Cross and Blue Shield Association.
℠Service Mark of the Blue Cross and Blue Shield Association.

APPLICATION FOR GROUP HEALTH INSURANCE
GROUP AND INDIVIDUAL DIVISION

BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA

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

COLUMBIA, SOUTH CAROLINA

www.SouthCarolinaBlues.com

Application is hereby made for group health insurance for the eligible Employees and Dependents or Members of the Group (herein referred to as the Applicant.) True Blue Plan 80/60 (Product Name(s)).

Name of Applicant: Greater Columbia
(Company's correct legal name)

Address of Applicant: 1010 Lincoln Street
(Physical) Columbia, SC 29201

Upon approval, the Effective Date of the Contract under this application shall be 12:01 a.m., standard time on the 1st day of August, 2018, and such coverage will continue until terminated in accordance with the provisions of the Contract between the Applicant and Blue Cross and Blue Shield of South Carolina.

Classification of Eligible Employees: All full-time, active Employees working at least 30 hours a week at least 48 weeks a year for the Applicant. To be considered Actively-at-work, the Employee must: 1) have begun work and not be absent from work because of leave of absence or temporary lay-off, unless the absence is due to a Health Status-related Factor other than substance abuse or chemical dependency; and 2) be performing the normal duties of his or her occupation at one of the Employer's normal places of business or at a location to which the Employee must travel to do his or her job.

Periods of Continuous Employment as Prerequisite to Eligibility: Coverage for new Employees hired following the Effective Date of the contract will begin:
- ☐ on the first monthly Effective Date following _____ days of employment
- ☒ on the first day following 090 days of employment

PARTICIPATION Requirements:

1. When the Employer pays 100% of the single coverage premium, all eligible Employees must enroll with at least single coverage.
2. When the Employer pays less than 100% of the single coverage premium:

Employee may elect not to receive coverage:
The number of Employees not electing coverage is determined by group size:

Total Full-time Eligible Employees	Allowed Number of Employee(s) Not Electing Coverage
Less than 4	None
4 to 7	1
8 to 11	3
12 to 14	4
More than 15	Minimum of 60% of total full-time must enroll.

Effective Date: The date the coverage goes into effect.

Enrollment Date: The date of enrollment in the group health plan or the first day of the Waiting Period for the enrollment, whichever is earlier.

Late Enrollee: An eligible Employee or Dependent who enrolls under this Contract other than during:

1. The first period in which the Employee or Dependent is eligible to enroll under the plan if the initial enrollment period is a period of at least 30 days; or
2. A Special Enrollment period.

Late Enrollees will be excluded from coverage for 12 months then have a six-month Pre-existing Condition Limitation.

®Registered Marks of the Blue Cross and Blue Shield Association.

Special Enrollment: If the Employee is eligible and not already enrolled, or if a Dependent is eligible and not already enrolled, the Corporation will allow the Employee or Dependent to enroll if either 1 or 2 below is met:

1. Each of the following must be met:
   a. The Employee or Dependent was covered under a Group Health Plan or had health insurance coverage at the time coverage was previously offered to the Employee or Dependent; and
   b. The Employee stated in writing at the time that coverage under a Group Health Plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer, if applicable, required such a statement at the time. The plan sponsor or issuer must have given the Employee a notice of the requirement and the consequences of the requirement at the time; and
   c. The Employee's or Dependent's coverage described in paragraph 1 above:
      i. Was under a COBRA or state continuation provision and the coverage under the provision was exhausted; or
      ii. Was not under a continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage or employer contribution toward the coverage stopped. Reasons for a loss of eligibility might include legal separation, divorce, death, termination of employment or reduction in the number of hours of employment;
      iii. Was one of multiple health insurance plans offered by an employer and the employee elects a different plan during an open enrollment period.
   d. The Employee requests the enrollment not later than 31 days after the date prior coverage ended due to loss of eligibility or Employer contribution stopped as described above.
2. a. The Employee or Dependent is covered under a Medicaid plan or under a State Children's Health Insurance Program (S-CHIP) and coverage of the Employee or Dependent under such plan is terminated due to loss of eligibility for such coverage and the Employee requests coverage under the Group Health Plan not later than 60 days after the termination date of such coverage; or
   b. The Employee or Dependent becomes eligible for assistance, with respect to coverage under the Group Health Plan under such Medicaid plan or State Children's Health Insurance Program (S-CHIP), if the Employee requests coverage under the Group Health Plan not later than 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If the Employee is eligible under the plan but is not enrolled, and he or she marries, the Employee and the new spouse may enroll in the plan if enrollment is requested within 31 days of the marriage.

If the Employee is eligible under the plan but not enrolled and the Employee or Employee's spouse has a child, adopts a child or a child is placed with the Employee or Employee's spouse for adoption, the new Dependent(s) may receive coverage under the plan. At the time of birth, adoption or placement for adoption, the Employee and Employee's spouse may also receive coverage. However, the Employee and Employee's spouse may be subject to the Pre-existing Condition Limitation period up to 12 months. Coverage must be requested within 31 days of the child's birth, adoption or placement for adoption.

Special Enrollees other than a newborn, adopted child or child placed for adoption may be subject to the Pre-existing Condition Limitation period up to 12 months.

PRE-EXISTING CONDITION LIMITATIONS

Any services or charges for services for Pre-existing Conditions are not covered under this Contract when the treatment relates to a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period prior to the Enrollment Date.

The Pre-existing Condition Exclusion period ends at the earliest of:

a. The date on which the member has not received medical care, treatment or supplies for the Pre-existing Condition for 12 months and that period of 12 months ends on or after the Effective Date of coverage; or
b. 12 months after the Enrollment Date. In the case of a Late Enrollee, 18 months after the date the Member completes the application for coverage (See Late Enrollee).

Creditable Coverage, which is calculated on a day-by-day basis, can reduce or eliminate the Pre-existing Condition Exclusion.

A period of Creditable Coverage does not count if there is at least a 63-day period where the Employee or eligible Dependent was not covered under any Creditable Coverage.

Any period that an Employee or Dependent is in a Waiting Period under a Group Health Plan may not be taken into account in determining the 63-day period.

The Corporation shall count a period of Creditable Coverage without regard to the specific health benefits covered during the period.

The Pre-existing Condition Limitations do not apply to Maternity Services or to Genetic Information in the absence of a diagnosis of the condition related to the information.

The Pre-existing Condition Limitations do not apply to a newborn child, a child who is adopted or placed with the Employee or Employee's spouse for the purpose of adoption before he or she reaches 18 years of age if the Employee applied for coverage and the premium was paid within 31 days from the birth, adoption or placement for adoption. If, however, the Employee or Dependent does not have Creditable Coverage after the end of the first 63-day period, the above newborn and adopted provisions do not apply.

If an Employee has single coverage and adds Dependents, the Pre-existing Condition Limitations apply to any Dependents as of the Effective Date of the upgraded coverage unless there is Creditable Coverage.

Creditable Coverage: Benefits or coverage provided under:
1. A group health plan;
2. Health Insurance Coverage;
3. Medicare Part A or B;
4. Medicaid, other than coverage having only benefits under Section 1928;
5. Military, TRICARE or CHAMPUS;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool, including the South Carolina Health Insurance Pool (SCHIP);
8. The Federal Employees Health Benefits Plan (FEHBP);
9. A public health plan, as defined in regulation;
10. A health benefit plan of the Peace Corps;
11. Short Term Health; or
12. A State Children's Health Insurance Program (S-CHIP).

This term does not include coverage for Excepted Benefits. Excepted Benefits is defined in the Contract.

The Corporation will count a period of Creditable Coverage without regard to specific health benefits covered during the period.

The period of any Pre-existing Condition exclusion is reduced or eliminated by the total periods of Creditable Coverage listed above.

It is understood and agreed that the Applicant shall pay Blue Cross and Blue Shield of South Carolina, in advance, the premiums specified in Schedule A of the Master Contract on behalf of the Applicant's Employees who meet the eligibility requirements as specified in this application and that this application when received by the Applicant, shall form a part of the Contract between Blue Cross and Blue Shield of South Carolina and the Applicant. Coverage is not effective unless and until approved by the Underwriting department at Blue Cross and Blue Shield of South Carolina's home office. The Applicant further understands and agrees that the premiums for the group policy must be paid by the policyholder from policyholder's funds or from funds contributed by the insured persons, or from both.

The Applicant hereby expressly acknowledges its understanding that this application constitutes a Contract solely between the Applicant and the Corporation. The Corporation is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. The "Association" permits the Corporation to use the Blue Cross and Blue Shield service marks in the State of South Carolina, and that the Corporation is not contracting as the agent of the Association.

The Applicant further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than the Corporation and that no person, entity or organization other than the Corporation shall be held accountable or liable to the Applicant for any of the Corporation's obligations to the Applicant created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of the Corporation other than those obligations created under other provisions of this Contract.

Dated at (City) Columbia, South Carolina, this 1st day of August, 2018

Greater Columbia
Name of Applicant (Company Name)

By: ______________________
(Authorized Signature)

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA

By: ______________________
(Authorized Signature)

SCHEDULE OF BENEFITS FOR BUSINESS TRUE BLUE[SM]

Employer Name:	Greater Columbia		
Client Number:	36434	Group Number:	05-81785-00
Client Effective Date:	August 1, 2010	Coverage Effective Date:	August 1, 2018
Anniversary Date:	January 01		
Benefit Period:	January 1st through December 31st		

Deductible - You pay — $750 each Benefit Period

Limited to three Deductibles per Family. Does not apply to the Out-of-pocket Expense.

Copayment - You pay

$25 Primary Care Physician (PCP) office visit - a PCP is a family doctor, general Physician, OB-GYN, pediatrician, osteopath or internal medicine Physician
$35 Specialist office visit
$25 Mental Health Services or Substance Abuse care office visit
$0 per admission at a Preferred Blue® Facility
$250 per admission for All Other Providers

Does not apply toward the Out-of-pocket Maximum and does not stop when the Out-of-pocket Maximum is reached.

Specialty Drug Copayment - You pay — 10% not to exceed $200 per Dose when obtained through a Specialty Drug Network Provider

Does not apply toward the Out-of-pocket Maximum and does not stop when the Out-of-pocket Maximum is reached.

Out-of-pocket Expenses - You pay — Preferred Blue® Providers - $1500 per Member or $3000 per Family per Benefit Period

Covered Expenses will be paid at 100% from Preferred Blue Providers after the Out-of-pocket Maximum is met except for Spinal Subluxation Services (if purchased).

All Other Providers - $3000 per Member or $6000 per Family per Benefit Period

Covered Expenses will be paid at 100% from All Other Providers after the Out-of-pocket Maximum is met except for Spinal Subluxation Services (if purchased).

Out-of-pocket Covered Expenses contribute to both Out-of-pocket Maximums. Coinsurance for Spinal Subluxation Services (if purchased) does not contribute to the Out-of-pocket Maximums, nor does the reimbursement percentage change from the amount indicated on the Schedule of Benefits.

Maximum Benefit - We pay

Per Member per Benefit Period limit:
30 visits for physical therapy, other than inpatient

Separate per Member Benefit Period Maximums apply to the following:
$500 for spinal subluxation services (if purchased)
$500 for Supplemental Accidental Injury (if purchased)
$300 for physical exam services not included in other covered Preventive services (if purchased)

All benefits payable on Covered Expenses are based on our Allowable Charges.
All covered services must be Medically Necessary.

All Admissions require Preadmission Review or Emergency Admission Review, and Continued Stay Review. If Preadmission Review is not obtained for all Facility Admissions, room and board will be denied. If approval is not obtained for Emergency Admissions within 24 hours or by 5 p.m. of the next working day following the Admission, room and board will be denied.

Treatment for the following services require Preauthorization Review: outpatient and office services for covered Mental Health Services (other than behavioral therapy for Autism Spectrum Disorder) and covered Substance Abuse care; outpatient chemotherapy or radiation therapy (first treatment only), hysterectomy, septoplasty and sclerotherapy. If Preauthorization is not obtained, appropriate Benefits will be paid after a 50% reduction in the Allowable Charge.

All cosmetic Surgery or procedures, Home Health Care, Hospice Care, human organ and/or tissue transplants, inpatient rehabilitation services, behavioral therapy for Autism Spectrum Disorder and Durable Medical Equipment (DME) when the purchase price or rental cost of the DME is $500 or more require Preauthorization Review. If Preauthorization is not obtained, no Benefits will be paid. Inpatient rehabilitation services must also be performed at a Designated Provider.

The following procedures require Preauthorization Review when performed outpatient or in the office: MRI, MRA, PET scan and CT scan. Please call National Imaging Associates (NIA) at 866-500-7664 for Preauthorization Review. If Preauthorization Review is not obtained, no Benefits will be paid. On behalf of Blue Cross® and Blue Shield® of South Carolina, National Imaging Associates (NIA) provides utilization management services for certain radiological procedures. National Imaging Associates is an independent company that preauthorizes certain radiological procedures.

For all other medical services that require Preauthorization Review and all Facility Admissions, please call 803-736-5990 in the Columbia area, 800-327-3238 toll-free in South Carolina and 800-334-7287 toll-free outside South Carolina. For Preauthorization Review for all Mental Health Services and Substance Abuse care, please call Companion Benefit Alternatives, Inc. at 803-699-7308 in the Columbia area and 800-868-1032 toll-free outside of Columbia. On behalf of Blue Cross and Blue Shield of South Carolina, Companion Benefit Alternatives, Inc. (CBA) preauthorizes Mental Health Services and Substance Abuse care. Companion Benefit Alternatives, Inc. is a separate company that preauthorizes behavioral health benefits.

PRESCRIPTION DRUGS **Drug Card**	**WE PAY CONTRACTING MAIL SERVICE PHARMACY**	**WE PAY PARTICIPATING NETWORK PHARMACIES**	**WE PAY NON-PARTICIPATING NETWORK PHARMACIES**
Generic, Preferred and Non-Preferred Drugs	100% per prescription or refill after you pay the Prescription Drug Copayment of: $16 for Generic Drugs $70 for Preferred Drugs $140 for Non-preferred Drugs Contraceptives are included. Benefits are limited to a 90-day supply. Only generic oral contraceptives are covered at 100%, no Copayment or Coinsurance. Refer to above described regular prescription benefits for Brand-named oral contraceptives.	100% per prescription or refill after you pay the Prescription Drug Copayment of: $8 for Generic and designated Over-the-counter Drugs $30 for Preferred Drugs $60 for Non-preferred Drugs Contraceptives are included. Benefits are limited to a 31-day supply or a 90-day supply with 3 Prescription Drug Copayments. Only generic oral contraceptives are covered at 100%, no Copayment or Coinsurance. Refer to above described regular prescription benefits for Brand-named oral contraceptives.	60% per prescription or refill after you pay the Prescription Drug Copayment of: $8 for Generic and designated Over-the-counter Drugs $30 for Preferred Drugs $60 for Non-preferred Drugs Contraceptives are included. Benefits are limited to a 31-day supply or a 90-day supply with 3 Prescription Drug Copayments.

If a Physician prescribes a Brand-name Drug for a specific medical reason and states there is to be no substitution of that drug, then Benefits are payable as specified in the Schedule of Benefits. If a Physician allows the substitution of a Brand-name Drug and the Member still requests the Brand-name Drug, then the Member must pay any difference between the cost of a Generic Drug and the higher cost of a Brand-name Drug.

	WE PAY SPECIALTY DRUG NETWORK PROVIDERS	**WE PAY ALL OTHER PHARMACY PROVIDERS**
Specialty Drugs	100% after you pay each Specialty Drug Copayment, not to exceed the amount for which prior approval was given.	No Benefits

	WE PAY PREFERRED BLUE PROVIDERS	**WE PAY ALL OTHER PROVIDERS**
Physician Services		
Physician charges for services in an outpatient Hospital or Clinic, including Surgery, (except Mental Health Services, Substance Abuse care and physical therapy), outpatient lab and X-ray services and all other miscellaneous services	80% after the Deductible	60% after the Deductible
Primary Care Physician (PCP) or Specialist non-routine/sick office charges to include the following: surgical services if for the treatment of an accident or injury; injections for allergy, tetanus and antibiotics; diagnostic lab and diagnostic X-ray services (such as chest X-rays and standard plain film X-rays), when performed in the Physician's office on the same date and billed by the Physician (does not include Mental Health Services, Substance Abuse care or maternity care)	100% after the Copayment	60% after the Deductible
Physician office charges for all other services, including Surgery, Second Surgical Opinion, consultation, maternity care, dialysis treatment, chemotherapy and radiation therapy and Specialty Drugs received or dispensed in a Physician's office (including the administration) and the reading/interpretation of diagnostic lab and X-ray services	80% after the Deductible	60% after the Deductible
Endoscopies (such as proctoscopy and laparoscopy) performed in a Physician's office, whether for diagnosis or treatment	80% after the Deductible	60% after the Deductible
High technology diagnostic services such as, but not limited to, MRIs, MRAs, PET scans, CT scans, ultrasounds, cardiac catheterizations, and procedures performed with contrast or dye	80% after the Deductible	60% after the Deductible
Preventive screenings according to: United States Preventive Services Task Force (USPSTF) recommendations A or B, Center for Disease Control and Prevention (CDC) recommendations for immunizations, Health Resources and Services Administration (HRSA) recommendations for children and women preventive care and screenings	100%	No Benefits
Preventive OB-GYN exam as recommended by the American Cancer Society	As covered by Preventive screenings	No Benefits
Preventive prostate screening/lab work as recommended by the American Cancer Society	100%	No Benefits
Preventive Pap smear as recommended by the American Cancer Society	As covered by Preventive screenings	No Benefits
Preventive colorectal cancer screening/testing as recommended by the American Cancer Society	As covered by Preventive screenings	No Benefits
Services related to a physical exam not included in other covered Preventive Screenings (limited to $300 per Benefit Period)	100%	No Benefits
Inpatient Physician charges for admissions in a Hospital (including initial newborn pediatric exam) and Skilled Nursing Facility, Surgery, anesthesia, radiology and pathology services (except Mental Health Services and Substance Abuse care)	80% after the Deductible	60% after the Deductible

	WE PAY PREFERRED BLUE PROVIDERS	WE PAY ALL OTHER PROVIDERS
Other Services		
Ambulance, medical supplies, ostomy bags and related supplies, Durable Medical Equipment (purchase or rental - Preauthorization is required if $500 or more), all other charges for out-of-country services or supplies (including outpatient Facility and Physician)	80% after the Deductible	60% after the Deductible
Home Health Care and Hospice Care with the required Preauthorization	80% after the Deductible	60% after the Deductible
Physical therapy (limited to 30 visits per Benefit Period, other than inpatient)	80% after the Deductible	60% after the Deductible
Spinal subluxation services (limited to $500 per Benefit Period)	Not Purchased	Not Purchased
Supplemental Accidental Injury (limited to $500 per Benefit Period)	Not Purchased	Not Purchased
Human Organ and Tissue Transplants When preapproved by the Corporation, human organ and/or tissue transplant Benefits are payable for all expenses for medical and surgical services and supplies while covered under this Contract.	80% after the Deductible	60% after the Copayment and the Deductible
Women's Preventive		
Facility charges billed separately and directly related to ligation, transection or occlusion of fallopian tubes	100%	Refer to Facility Benefits
Physician, lab and X-ray charges directly related to ligation, transection or occlusion of fallopian tubes	100%	60% after the Deductible
Breastfeeding equipment - purchase only; through a doctor's office, Pharmacy or Durable Medical Equipment supplier only. Limited to one per twelve month period.	100%	No Benefits
The following contraceptive devices or services: Generic injections, Mirena IUD, Nexplanon implant, Ortho Evra patch, Nuvaring, Ortho Flex, Ortho Coil, Ortho Flat, Wide-seal, Omniflex, Prentif and Femcap-vaginal	100%	60% after the Deductible
All other covered contraceptive devices or services not specifically listed	80% after the Deductible	60% after the Deductible
Mental Health Services and Substance Abuse Benefits		
Inpatient Facility charges	80%	60% after the Deductible
Inpatient Physician charges	80%	60% after the Deductible
Outpatient Facility (other than Emergency Room)/Physician (other than office visit) charges	80% after the Deductible	60% after the Deductible
Emergency Room charges	80% after the Deductible	80% after the Deductible
Physician office charges	100% after the Copayment	60% after the Deductible

	WE PAY APPROVED PROVIDERS	WE PAY ALL OTHER PROVIDERS
Mental Health Services Benefits		
Behavioral therapy - behavioral modification using applied behavioral analysis (ABA) for Autism Spectrum Disorder by a Board Certified Behavioral Analyst or approved Provider. Behavioral therapy does not include educational or alternative programs such as, but not limited to: TEACCH, auditory integration therapy, higashi schools/daily life, facilitated communication, floor time, relationship development intervention (RDI), holding therapy, movement therapies, music therapy and pet therapy. Preauthorization of the treatment plan by Companion Benefit Alternatives, Inc. is required. On behalf of Blue Cross and Blue Shield of South Carolina, Companion Benefit Alternatives preauthorizes Mental Health Services and Substance Abuse services. Companion Benefit Alternatives is a separate company that preauthorizes behavioral health benefits.	80% after the Deductible	Not Covered

	PREFERRED BLUE PROVIDERS	ALL OTHER PROVIDERS
Facility Benefits		
Inpatient Hospital (other than for Mental Health Services or Substance Abuse care), Skilled Nursing Facility and out-of-country Facility charges	80%	60% after the Copayment and the Deductible
Inpatient Rehabilitation services (must be Preauthorized by the Corporation and performed at a Designated Provider)	80%	60% after the Copayment and the Deductible
Outpatient Hospital or Clinic charges for medical and surgical services, preadmission testing, lab and X-ray services and all other miscellaneous services	80% after the Deductible	60% after the Deductible

	WE PAY MAMMOGRAPHY NETWORK PROVIDER	WE PAY ALL OTHER PROVIDERS
Mammography Benefits		
Routine mammography screening according to the United States Preventive Services Task Force (USPSTF) recommendations A or B	100%	No Benefits

Group Name: Greater Columbia
Group Number: 05-81785-00
Client Number: 36434
Effective Date: August 1, 2018

SCHEDULE A

Premiums for the insurance applied for shall be as follows:

Monthly Premiums

Types of Membership	Single	Family	Emp/Spouse	Emp/Child
Comprehensive Preferred Personal Medical Expenses	$ 699.26	$2,309.13	$1,800.63	$1,207.76
Total Premiums	$ 699.26	$2,309.13	$1,800.63	$1,207.76

Initial charges shall be payable in advance of the Effective Date. Subsequent premiums shall be payable on or before the same date of each month thereafter. In no event shall coverage hereby applied for become effective until payment for the initial premiums is received by Blue Cross and Blue Sheild of South Carolina.

Blue Cross and Blue Shield of South Carolina may change the monthly premiums when benefits under the Contracts are changed by amendment or as of any monthly due date upon giving thirty-one (31) days prior written notice to Applicant, when such action is taken as to all Contracts in the class to which the Contract belong.

BlueCross BlueShield of South Carolina
I-20 at Alpine Road
Columbia, SC 29219-0001
803.788.0222

SouthCarolinaBlues.com

An Independent Licensee of the Blue Cross and Blue Shield Association

July 2018

Greater Columbia
1010 Lincoln Street
Columbia, SC 29201

Dear Benefits Coordinator:

We are pleased to inform you that your group's health plan drug benefit is **creditable coverage**. That means your drug benefit is equal to or better than Medicare's prescription drug plan. The Medicare Modernization Act requires you to provide this information to Medicare-eligible employees enrolled in your group health plans.

Why is this important?
Medicare-eligible individuals who have creditable prescription drug coverage can enroll in a Medicare Part D prescription drug plan after their initial eligibility period and do not have to pay a late enrollment fee. However, if they drop or lose creditable coverage for 63 or more days in a row before enrolling, they will pay a late-enrollment penalty.

What do you need to do?
Please give the enclosed notice to your Medicare-eligible employees (and eligible dependents) covered under your plan. Also, each year you must notify the Centers for Medicare & Medicaid Services (CMS) that your group's coverage is creditable or not creditable to Medicare's prescription drug plan. We have enclosed guidelines that explain how you should notify CMS.

You and your employees can learn more about Medicare Part D at Medicare.gov. If you have questions, please contact BlueCross customer service toll free at 800-868-2500, ext. 41010.

Sincerely,

Manny Licata
Vice President
Group and Individual Operations

Enclosures

Important Notice from BlueCross® BlueShield® of South Carolina About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with BlueCross and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage plans that offer prescription drug coverage. **All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **BlueCross has determined that your prescription drug coverage is**, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered **Creditable Coverage**.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare, and each year from October 15 through December 7. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you decide to enroll in a Medicare prescription drug plan and drop your BlueCross prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

The details of your current coverage are as follows:

Effective Date of Coverage: **August 1, 2018**

Type of Prescription Drug Plan: **Drug Card $8/$30/$60**

BlueCross Group Number: **05-81785-00**

You should also know that if you drop or lose your coverage with BlueCross and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association, an association of independent BlueCross and Blue Shield Plans.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your premium will go up at least 1 percent per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage:

Contact BlueCross customer service at 803-264-1010 or toll free at 800-868-2500, ext. 41010.
NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through BlueCross changes. You also may request a copy of this notice.

For more information about your options under Medicare prescription drug coverage:

Read the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. Medicare-approved prescription drug plans may also contact you directly. For more information about Medicare prescription drug plans:

- Visit Medicare.gov.
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for its telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at SocialSecurity.gov, or you can call 800-772-1213 (TTY: 800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare that offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: July 2, 2018
Name of Entity/Sender: Greater Columbia
Contact - Position/Office: The Contact Person
Address: 1010 Lincoln Street Columbia, SC 29201

Phone Number: The Contact Person

CMS NOTIFICATION GUIDELINES

How to notify CMS of your creditable or non-creditable coverage status

Who Must Provide the Disclosure Notice to CMS

All employers who provide group health coverage, offer prescription drug coverage and have Medicare-eligible individuals covered under their plans must notify the Centers for Medicare & Medicaid Services (CMS) annually as to whether their coverage is creditable or not creditable to Medicare's prescription drug plan.

These employers must complete the online Disclosure Notice and submit it to CMS annually and any time there is a change in the drug coverage that affects the creditable coverage status. At a minimum, employers must also provide the disclosure to CMS at these times:

1. For plan years that end in 2007 and beyond, disclosure of creditable coverage status must be submitted within 60 days after the beginning date of the plan year for which the entity is providing the disclosure to CMS.

2. Within 30 days after the termination of the prescription drug plan.

3. Within 30 days after any change in the creditable coverage status of the prescription drug plan

Completing the CMS Disclosure Form

For more information about CMS requirements, go to the CMS Creditable Coverage Disclosure Web page at http://www.cms.hhs.gov/creditablecoverage. There you will find the Disclosure to CMS Guidance document. The Disclosure to CMS Form may be accessed under the "Related Links Inside CMS" heading located on this page.

The form is also located at http://www.cms.hhs.gov/CreditableCoverage/45_CCDisclosureForm.asp.
All employers must complete the online Disclosure Form. There is no paper (or printable) form available

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BOOKLET INSERT

(The following revision should not be construed as a complete replacement of the section in your Benefit Booklet unless otherwise noted.)

This supplement to your Benefit Booklet is effective for new and renewing groups on or after January 1, 2013.

The Claims Determination in the *Claims Filing* section has been revised as follows. The revision should not be construed as a complete replacement of the section:

If a federal court determines the plan administrator is required to pay a penalty for not providing requested material within 30 days, the penalty has been changed from $100 a day to $110 a day.

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BOOKLET INSERT

(The following additions/revisions should not be construed as a complete replacement of the sections in your Benefit Booklet unless otherwise noted.)

This supplement to your Benefit Booklet is effective for new and renewing groups on or after August 1, 2012.

The *Out-of-Area Services* section is modified by the deletion of the first paragraph and the following substituted. The revision should not be construed as a complete replacement of the section:

Blue Cross and Blue Shield of South Carolina has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain health care services outside of Blue Cross and Blue Shield of South Carolina's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program.

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Continuation of Care Booklet Insert

(The following additions/revisions should not be construed as a complete replacement of the sections in your Benefit Booklet unless otherwise noted.)

This supplement to your Benefit Booklet is effective for new and renewing groups on or after January 1, 2011.

The Benefit Booklet is modified by the addition of the following section:

Continuation of Care

If a Preferred Blue℠ Provider's contract ends or is not renewed for any reason other than suspension or revocation of the Provider's license, you may be eligible to continue to receive in-network Benefits for that Provider's services.

If you are receiving treatment for a Serious Medical Condition at the time a Preferred Blue Provider's contract ends, you may be eligible to continue to receive treatment from that Provider. In order to receive this continuation of care for a Serious Medical Condition, you must submit a request to us on the appropriate form.

You may get the form for this request by going to our website at www.SouthCarolinaBlues.com or calling 803-264-1000 in Columbia or 800-868-2500, ext, 41000 outside the Columbia area. You will also need to have the treating Provider include a statement on the form confirming that you have a Serious Medical Condition. Upon receipt of your request, we will notify you and the Provider if the last date the Provider is part of our network and a summary of continuation of care requirements. We will review your request to determine if you qualify for the continuation of care. If additional information is necessary to make a determination, we may contact you or the Provider for such information.

If we approve your request, we will provide in-network Benefits for that Provider for 90 days or until the end of the Benefit Period, whichever is greater. During this time, the Provider will accept the network allowance as payment in full. Continuation of care is subject to all other terms and conditions of this Contract, including regular Benefit limits.

The *Definitions* section is modified by the addition of the following. The addition should not be construed as a complete replacement of the section:

Serious Medical Condition: A health condition or illness that requires medical attention, and for which failure to provide the current course of treatment through the current Provider would place your health in serious jeopardy. This includes cancer, acute myocardial infarction and pregnancy.

THE BLUECARD® PROGRAM AMENDMENT

This Amendment is subject to all provisions of the Contract between the Employer and the Corporation, which are not otherwise specified in the provisions of this Amendment.

This Amendment is effective for new and renewal groups on or after February 1, 2011.

ARTICLE III – COVERED SERVICES, is amended by the deletion of **3., BlueCard® Program**, and the following Out-of-Area Services substituted therefore:

5. Out-of-Area Services

Blue Cross and Blue Shield of South Carolina has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever Members access health care services outside the geographic area Blue Cross and Blue Shield of South Carolina serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to us for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this agreement are described generally below.

Typically, Members, when accessing care outside the geographic area we serve, obtain care from health care Providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, Members may obtain care from non-participating health care Providers. Our payment practices in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when Members access covered health care services within the geographic area served by a Host Blue, we will remain responsible to the Employer for fulfilling our contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating health care Providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

Liability Calculation Method Per Claim

The calculation of the Member liability on claims for covered health care services processed through the BlueCard Program will be based on the lower of the participating health care Provider's billed covered charges or the negotiated price made available to us by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue’s health care Provider contracts. The negotiated price made available to us by the Host Blue may represent a payment negotiated by a Host Blue with a health care Provider that is one of the following:

(i) an actual price. An actual price is a negotiated payment without any other increases or decreases, or

(ii) an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

(iii) an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its health care Providers or a similar classification of its Providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to Providers or anticipated to be paid to or received from Providers). However, the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to us is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

A small number of states require a Host Blue either (i) to use a basis for determining Member liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should the state in which health care services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, we would then calculate Member liability in accordance with applicable law.

Return of Overpayments
Under the BlueCard Program, recoveries from a Host Blue or its participating health care Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, health care Provider/ hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by--claim or prospective basis.

B. Non-Participating Health Care Providers Outside Our Service Area

1. Member Liability Calculation
   When covered health care services are provided outside of our service area by non-participating health care Providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's non-participating health care Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the non-participating health care Provider bills and the payment we will make for the covered services as set forth in this paragraph.

2. Exceptions
   In some exception cases, we may pay claims from non-participating health care Providers outside of our service area based on the Provider's billed charge, such as in situations where a Member did not have reasonable access to a participating Provider, as determined by us in our sole and absolute discretion or by applicable state law. In other exception cases, we may pay such a claim based on the payment we would make if we were paying a non-participating Provider inside of our service area, as described elsewhere in this Contract, where the Host Blue's corresponding payment would be more than our in-service area non-participating Provider payment, or in our sole and absolute discretion, we may negotiate a payment with such a Provider on an exception basis. In any of these exception situations, the Member may be responsible for the difference between the amount that the non-participating health care Provider bills and payment we will make for the covered services as set forth in this paragraph.

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THE BLUECARD® PROGRAM INSERT

(The following additions/revisions should not be construed as a complete replacement of the sections in your Benefit Booklet unless otherwise noted.)

This supplement to your Benefit Booklet is effective for new and renewal groups on or after February 1, 2011.

***The BlueCard® Program s*ection has been deleted in its entirety and replaced with the following:**

Out-of-Area Services

Blue Cross and Blue Shield of South Carolina has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain health care services outside of Blue Cross and Blue Shield of South Carolina's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside our service area, you will obtain care from health care Providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating health care Providers. Our payment practices in both instances are described below.

A. BlueCard® Program

Under the BlueCard Program, when you access covered health care services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care Providers.

Whenever you access covered health care services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered health care services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered health care services according to applicable law.

B. Non-Participating Health Care Providers Outside Our Service Area

1. Member Liability Calculation

   When covered health care services are provided outside of our service area by non-participating health care Providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating health care Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating health care Provider bills and the payment we will make for the covered services as set forth in this paragraph.

2. Exceptions

   In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the health care services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by non-participating health care Providers. In these situations, you may be liable for the difference between the amount that the non-participating health care Provider bills and the payment we will make for the covered services as set forth in this paragraph.

HEALTH CARE REFORM AMENDMENT

This Amendment is subject to all provisions of the Contract between the Employer and the Corporation, which are not otherwise specified in the provisions of this Amendment.

Blue Cross and Blue Shield of South Carolina believes this **plan** 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 plan 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 the Corporation at 803-264-1010 or toll free at 800-868-2500, extension 41010.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

This Amendment is effective for “grandfathered” health plans renewing on or after September 23, 2010.

Dependent Child

ARTICLE I – DEFINITIONS, is amended by the deletion of paragraph 24. and the following substituted therefore:

24. **Dependent:** Any covered Member of the Employee’s family: a) spouse; and/or b) Dependent children through age 25. A Dependent child can be a natural child, legally adopted child, stepchild, foster child or a child under legal guardianship.

    This also includes any child of a divorcing/divorced Employee who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under this health plan.

    Under the Patient Protection and Affordable Care Act and the Health Coverage and the Education Reconciliation Act, a Dependent child does not include an individual who is eligible for other employer sponsored coverage if the Group Health Plan is a grandfathered plan for plan years beginning before January 1, 2014.

The Contract is further revised to remove all references to Full-time Student and all dependent age references have been revised to state through age 25.

Lifetime and Annual Maximums

All references to lifetime maximums have been deleted.

All references to Benefit Period maximums for specific services have been deleted except as specified in the Schedule of Benefits. A per Member, per Benefit Period maximum is noted in the Schedule of Benefits.

Pre-existing Condition Exclusion for Members Under Age 19

All references to the Contract’s Pre-existing Conditions Limitations will not apply to Members who enroll in the Group Health Plan when they are under the age of 19.

Preventive Benefits

ARTICLE III – COVERED SERVICES, is revised as follows:

All references to “Optional Preventive Benefits” or “Routine Preventive Benefits” have been deleted and replaced with the following:
Preventive screenings – According to the following:

- United States Preventive Services Task Force (USPSTF) recommendations Grade A or B

- Center for Disease Control and Prevention (CDC) recommendations for immunizations
- Health Resources and Services Administration (HRSA) recommendations for children and women preventive care and screenings

A Preferred Blue Provider must provide the services.

Rescission of Coverage

ARTICLE VIII – TERMINATION AND RENEWAL OF THIS CONTRACT, is amended by the deletion of paragraph 2 and the following substituted therefore:

2. If any of the following occurs, coverage will end for an Employee and/or his or her Dependent(s) on the last day of the month specified by the Employer, except as provided in this Article and subsequent Articles X and XI:
   - A Member ceases to be eligible
   - The Employer notifies the Corporation that coverage of a Member is to be terminated
   - This Contract is cancelled by the Employer or non-renewed by the Corporation

   If the Employer notifies the Corporation of the termination of an Employee's coverage other than on a timely basis, there will be no retroactive credit adjustment. The Employee's rights to carry Creditable Coverage forward must not be compromised.

   i. It is the Employer's responsibility to ensure any retroactive Member termination forwarded to the Corporation is in compliance with federal law, specifically, that such termination was due to either:
      a. A Member's fraudulent act, practice or omission, or
      b. A Member's intentional misrepresentation of material fact, or
      c. A Member's failure to timely pay required premiums or contributions towards the cost of coverage.

      The Employer is solely responsible for providing to the Member any notice related to retroactive terminations or rescissions that are required by law.

   ii. Other than as expressly required by law, if this Contract is terminated for any reason, the Employer is solely responsible for notifying all Members of such termination and coverage of Members will not continue beyond the termination date.

   iii. The Employer agrees to indemnify and hold the Corporation and hold the Corporation harmless for all damages, claims, causes of action, costs and expenses (including a reasonable attorney's fee) arising out of or relating to the Employer's failure to notify Members of termination of this Contract, or any other notification required to be given to Members by the Employer.

   Exception: Employees may be considered as remaining in the active employment for purposes of coverage under this Contract during a disability leave of absence for a period not to exceed 60 days from the date of cessation of active work or for a qualified Employee, during a leave pursuant to the Family and Medical Leave Act of 1993.

   If an Employee on leave pursuant to the Family and Medical Leave Act fails to pay the Employee portion of the premium within a 31-day grace period and his or her coverage ends, the coverage of the Employee will be reinstated without new Waiting Periods as long as the Employee returns to work immediately after the leave period, re-enrolls and pays his or her portion of the then current premium within 31 days.

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HEALTH CARE REFORM BOOKLET INSERT

(The following additions/revisions should not be construed as a complete replacement of the sections in your Benefit Booklet unless otherwise noted.)

This supplement to your Benefit Booklet is effective for "grandfathered" health plans renewing on or after September 23, 2010.

Blue Cross and Blue Shield of South Carolina believes this **plan** 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 plan 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 the Corporation at 803-264-1010 or toll free at 800-868-2500, extension 41010.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Dependent Child

The Definitions section is modified by the revision of the following definition. The revision should not be construed as a complete replacement of the section:

Dependent: Your spouse and any children through age 25. A Dependent child can be a natural child, legally adopted child, stepchild, foster child or a child under legal guardianship.

This also includes any child of a divorcing/divorced Employee who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under this health plan.

Under the Patient Protection and Affordable Care Act and the Health Coverage and the Education Reconciliation Act, a Dependent child does not include an individual who is eligible for other employer sponsored coverage if the Group Health Plan is a grandfathered plan for plan years beginning before January 1, 2014.

The benefit booklet is further revised to remove all references to Full-time Student and all dependent age references have been revised to state through age 25.

Lifetime and Annual Maximums

All references to lifetime maximums have been deleted.

All references to Benefit Period maximums for specific services have been deleted except as shown in your Schedule of Benefits. A per Member, per Benefit Period maximum is noted in your Schedule of Benefits.

Pre-existing Condition Exclusion for Members Under Age 19

All references to the Group Health Plan's Pre-existing Conditions Limitations will not apply to Members who enroll in the Group Health Plan when they are under the age of 19.

Preventive Benefits

All references to "Optional Preventive Benefits" or "Routine Preventive Benefits" in the Covered Expenses section have been deleted and replaced with the following:

Preventive screenings – According to the following:
- United States Preventive Services Task Force (USPSTF) recommendations Grade A or B
- Center for Disease Control and Prevention (CDC) recommendations for immunizations
- Health Resources and Services Administration (HRSA) recommendations for children and women preventive care and screenings

A Preferred Blue Provider must provide the services.

Rescission of Coverage

The Eligibility section under Eligibility and Coverage has been revised by the addition of the following paragraph. The revision should not be construed as a complete replacement of the section:

A rescission does not include a retroactive cancellation or discontinuance of your coverage due to the failure to timely pay premiums. The Employer is solely responsible for providing you any notice related to retroactive terminations or rescissions that are required by law.

Other than as expressly required by law, if this coverage is terminated for any reason, the Employer is solely responsible for notifying you of such termination and your coverage will not continue beyond the termination date.

SPECIAL ENROLLMENT AMENDMENT

This Amendment is subject to all provisions of the Contract between the Employer and the Corporation, which are not otherwise specified in the provisions of this Amendment.

This Amendment is effective for new and renewal groups beginning April 1, 2009.

ARTICLE II – ELIGIBILITY FOR COVERAGE, is amended by the deletion of paragraph 5. and the following substituted therefore:

5. **Special Enrollment**
   If the Employee (or a Dependent) is eligible for coverage but has not already enrolled, the Corporation will allow the Employee or Dependent to enroll if either a or b below is met:

   a. Each of the following must be met:
      1. The Employee or Dependent was covered under a Group Health Plan or had Health Insurance Coverage at the time coverage was previously offered to the Employee or Dependent; and
      2. The Employee stated in writing at the time that coverage under a Group Health Plan or Health Insurance Coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at the time. The plan sponsor or issuer must have given the Employee a notice of the requirement and the consequences of the requirement at the time; and
      3. The Employee's or Dependent's coverage described in paragraph 1 above:
         i. Was under a COBRA or state continuation provision and that coverage had ended; or
         ii. Was not under a continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage or employer contribution toward the coverage stopped. Reasons for a loss of eligibility might include legal separation, divorce, death, termination of employment or reduction in the number of hours of employment; or
         iii. Was one of multiple health insurance plans offered by an employer and the Employee chose another plan during an open enrollment period.
      4. The Employee requests the enrollment not later than 31 days after the date coverage ended due to loss of eligibility or Employer contribution stopped as described above.

   b. 1. The Employee or Dependent is covered under a Medicaid plan or under a State Children's Health Insurance Program (S-CHIP) and coverage of the Employee or Dependent under such plan is terminated due to loss of eligibility for such coverage and the Employee requests coverage under the Group Health Plan not later than 60 days after the termination date of such coverage; or
      2. The Employee or Dependent becomes eligible for assistance, with respect to coverage under the Group Health Plan under such Medicaid plan or State Children's Health Insurance Program (S-CHIP), if the Employee requests coverage under the Group Health Plan not later than 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

   If the Employee is eligible under the plan but is not enrolled, and he or she marries, the Employee and the new spouse can enroll in the plan if enrollment is requested within 31 days of the marriage.

If the Employee is eligible under the plan but not enrolled and the Employee or Employee's spouse has a child, adopts a child or is in the process of adopting a child, the child can receive coverage under the plan. At the time of birth, adoption or placement for adoption, the Employee and Employee's spouse can also receive coverage as long as the eligibility requirements of this Contract are met. Coverage must be requested within 31 days of the child's birth, adoption or placement for adoption.

Special Enrollees other than newborns, adopted children or children placed for adoption may be subject to the Pre-existing Condition exclusion period up to 12 months.

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SPECIAL ENROLLMENT BOOKLET INSERT

(The following additions/revisions should not be construed as a complete replacement of the sections in your Benefit Booklet unless otherwise noted.)

This supplement to your Benefit Booklet is effective for new and renewal groups on or after April 1, 2009.

***Special Enrollment* in the *Eligibility and Coverage* section has been deleted in its entirety and replaced with the following:**

Special Enrollment

If you (or your Dependent) are eligible for coverage but have not already enrolled, we will let you enroll if you meet either 1 or 2 below:

1. You must meet each of the following:
    a. You or your Dependent was covered under a Group Health Plan or had Health Insurance Coverage at the time coverage was previously offered to you or your Dependent.
    b. You stated in writing at the time that coverage under a Group Health Plan or Health Insurance Coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at the time. The plan sponsor or issuer must have given you a notice of the requirement and the consequences of the requirement at the time.
    c. You or your Dependent's coverage described in paragraph a above:
        i. Was under a COBRA or state continuation provision and that coverage had ended; or
        ii. Was not under a continuation provision and the coverage ended either because you lost eligibility or because employer contributions toward the coverage stopped. Reasons for a loss of eligibility might include legal separation, divorce, death, end of employment or reduction in the number of hours of employment; or
        iii. Was one of multiple health insurance plans offered by an employer and you chose another plan during an open enrollment period.
    d. You request the enrollment no later than 31 days after the date coverage ended due to loss of eligibility or Employer contributions stopped as described above.

2. a. You or your Dependent is covered under a Medicaid plan or under a State Children's Health Insurance Program (S-CHIP) and coverage of you or your Dependent under such plan is terminated due to loss of eligibility for such coverage and you request coverage under the Group Health Plan not later than 60 days after the termination date of such coverage; or
    b. You or your Dependent becomes eligible for assistance, with respect to coverage under the Group Health Plan under such Medicaid plan or State Children's Health Insurance Program (S-CHIP), if you request coverage under the Group Health Plan not later than 60 days after the date you or your Dependent is determined to be eligible for such assistance.

If you're eligible under this plan, but aren't enrolled and you marry, then you and your new spouse can enroll in the plan if enrollment is requested within 31 days of the marriage.

If you're eligible under this plan, but aren't enrolled and you or your spouse has a child, adopts a child or is in the process of adopting a child, the child can receive coverage under the plan. At the time of birth, adoption or placement for adoption, you and your spouse can receive coverage as long as you meet the eligibility requirements of the Contract. You must request coverage within 31 days of the child's birth, adoption or placement for adoption.

Special Enrollees, other than newborns, adopted children or children placed with you or your spouse for adoption, may be subject to the Pre-existing Condition exclusion period up to 12 months.

AMENDMENT

This Amendment is subject to all provisions of the Contract between the Employer and the Corporation, which are not otherwise specified in the provisions of this Amendment.

This Amendment is effective for new and renewal groups beginning January 1, 2009.

The contract is amended by the deletion of Article VII and the following substituted therefore:

ARTICLE VII – EMPLOYER'S PERSONNEL DATA

1. The Employer, as plan administrator, is solely responsible in a timely fashion for furnishing the information that the Corporation requires for the purpose of enrolling Employees of the Employer under this Contract, processing terminations and effecting changes in family and membership status and transfers of employment of covered Employees.

   Upon the Employer's request, the Corporation will supply the Employer with forms that will present required information in a format convenient for the Corporation's use. Failure of the Employer to request such forms will not relieve the Employer of its duties to transmit the information.

   The Employer, after a reasonable investigation, believes the accuracy of the information it transmits to the Corporation to be correct and understands that the Corporation will rely on this information. The Employer further agrees to indemnify the Corporation for all expenses incurred, if any, as a result of the Employer's failure to transmit the information, failure to transmit it in the time period required by federal or state regulation and/or failure to transmit the correct information. As used here the term "expenses" includes, without limitation, any Benefits the Corporation may be required to pay beyond those required according to the information the Employer furnished to the Corporation, attorneys fees, court costs, penalties and uncollected premiums.

   Nothing contained in this Article will be construed to expand or otherwise alter the Benefits provided for Members under this Contract.

2. An Employer is liable for any penalty that may be imposed on the Corporation by a federal or state regulatory body when the Employer fails to provide required information on a timely basis.

3. Any agent assisting an Employer with enrollment or other transactions, including that of its Employees, is representing the Employer not the Corporation.

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Scott Graves
President
Blue Cross and Blue Shield Division

MENTAL HEALTH PARITY AMENDMENT

This Amendment is subject to all provisions of the Contract between the Employer and the Corporation, which are not otherwise specified in the provisions of this Amendment.

This Amendment is effective for new and renewal groups on or after October 15, 2009.

ARTICLE I – DEFINITIONS, is amended by the deletion of paragraphs 12., 44., 55., 60. and 92. and the following substituted therefore:

12. **Coinsurance:** The percentage of Allowable Charge for Covered Expenses a Member must pay. This percentage applies to the negotiated rate or lesser charge when the Corporation has negotiated rates with that Provider. Coinsurance amounts apply to the Out-of-pocket Maximum as specified in the Schedule of Benefits.

44. **Hospital:** A short-term, acute-care Facility that:

    a. Is licensed and operated according to the law; and
    b. Primarily and continuously provides or operates medical, diagnostic, therapeutic and major surgical facilities for the medical care and treatment of injured or sick people on an inpatient basis. It must also be under the supervision of a staff of duly licensed Physicians; and
    c. Provides 24-hour nursing services by or under the supervision of registered nurses (RNs).

    The term "Hospital" does not include long-term, chronic-care institutions or institutions that are, other than incidentally:

    a. Convalescent, rest or nursing homes or facilities; or
    b. Facilities primarily affording custodial, educational or rehabilitory care; or
    c. For the treatment of substance or alcohol abuse; or
    d. For the treatment of mental conditions.

    A Hospital does not include a long-term, chronic-care institution or Facility that mainly provides care for items (a) through (d) above, whether or not such institution or Facility is affiliated with or part of a Hospital.

55. **Mental Health Services:** The treatment of mental conditions. These conditions are defined, described or classified as psychiatric disorders or conditions in the latest publication of The American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders. As used in the health plan, this does not include services for the treatment of Substance Abuse.

60. **Out-of-pocket Maximum:** The maximum amount of Coinsurance for Covered Expenses the Member will have to pay during a Benefit Period for certain services as specified in the Schedule of Benefits.

    Coinsurance on certain services specified in the Schedule of Benefits does not apply toward the Out-of-pocket Maximums. These services will be paid as shown in the Schedule of Benefits regardless of Out-of-pocket Maximums.

    Certain other expenses also do not qualify toward the Out-of-pocket Maximums. They include the difference in an All Other Provider's fee and the Corporation's Allowed Charge, the Deductible, Copayments and charges for non-covered services by any Provider.

92. **Substance Abuse:** The continued use, abuse and/or dependence of legal or illegal substance(s), despite significant consequences or marked problems associated with the use as defined, described or classified in the latest publication of The American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders. As used in the health plan, this does not include services for treatment of Mental Health Services.

ARTICLE III – COVERED SERVICES, is amended by the deletion of paragraph 2.e. and the following substituted therefore:

2.e. **Preauthorization for Mental Health Services and Substance Abuse care** – Companion Benefit Alternatives, Inc. (CBA) must preapprove for Medical Necessity all inpatient, outpatient or office treatment as noted in the Schedule of Benefits. The Member, the Member's family or the Physician or the Hospital (if a Preferred Blue Provider) must call Companion Benefit Alternatives, Inc. at the number given on the ID card. On behalf of Blue Cross and Blue Shield of South Carolina, Companion Benefit Alternatives, Inc. (CBA) preauthorizes Mental Health Services and Substance Abuse care. Companion Benefit Alternatives, Inc. is a separate company that preauthorizes behavioral health benefits.

ARTICLE V ‑ EXCLUSIONS AND LIMITATIONS, is amended by the deletion of paragraphs 1.i., 1.w. and 1.ab. and the following substituted therefore:

1.i. Sanitarium care or rest cures; long-term, residential care for the treatment of Mental Health Services or Substance Abuse care, to include: residential treatment centers, therapeutic schools, wilderness/boot camps, therapeutic boarding homes, half-way houses and therapeutic group homes; or custodial care (domiciliary care), that being defined as care mainly designed to assist people to meet their daily living activities, such as, but not limited to, services which constitute personal care including: help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diet and supervision of medications which can usually be self-administered and which does not require continuous attention of trained Medical Personnel.

1.w. Recreational, educational or play therapy; bio-feedback; psychological or educational diagnostic testing to determine job or occupational placement, school placement or for other educational purposes, or to determine if a learning disorder exists; therapy for learning disorders, developmental speech delay, communication disorder, developmental coordination disorder, mental retardation, dissociative disorder, sexual and gender identity disorder, personality disorder and vocational rehabilitation unless specifically included in the Schedule of Benefits.

1.ab. Marriage or family counseling for premarital, marital or family relationship dysfunctions.

ARTICLE V ‑ EXCLUSIONS AND LIMITATIONS, is amended by the addition of paragraph 1.bd.:

1.bd. Counseling and psychotherapy services for: feeding and eating disorders in early childhood and infancy; tic disorder except for Tourette's disorder; elimination disorder; mental disorders due to general medical conditions; sexual function disorder; sleep disorder; medication induced movement disorder; and nicotine dependence unless specifically covered in this Contract.

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MENTAL HEALTH PARITY BOOKLET INSERT

(The following additions/revisions should not be construed as a complete replacement of the sections in your Benefit Booklet unless otherwise noted.)

This supplement to your Benefit Booklet is effective for new and renewal groups on or after October 15, 2009.

The *How Your Coverage Works* section is modified by the revision of the following:

How Your Coverage Works

To better understand how your coverage works, it's helpful to know some common insurance terms. One of the most common terms you'll find throughout this booklet is **Benefit**. It refers to the amount this plan pays for Covered Expenses. **Before we pay Benefits on most expenses, you or your insured family Member must meet a Deductible as shown in your Schedule of Benefits each Benefit Period**.

As we process your claims, we'll credit Allowed Charges to the Deductible shown in your Schedule of Benefits. Once you have met the Deductible shown in your Schedule of Benefits, we pay Benefits for covered services at a percentage of the Allowed Charges for the rest of the Benefit Period. This is called the **Benefit percentage**. The difference between the Allowed Charges and the Benefit percentage is called **Coinsurance**. For example, if the Benefit percentage is 80 percent of Allowed Charges, the Coinsurance is 20 percent. Your coverage pays the Benefit percentage, while you are responsible for paying the Coinsurance portion of the bill. The Deductible applies to all Covered Expenses unless otherwise noted.

Another common term is **Maximum Benefits Payable**. This refers to the amount a plan will pay per Member on a yearly or life-time basis. This plan, like other insurance plans, has limits on the amount payable during a Benefit Period and during the life-time of your coverage. When we have paid the lifetime maximum Benefits, no additional payments will be made on claims.

There are certain preventive services that we pay Benefits at 100 percent of the Allowed Charge for covered services after you have met any required Copayment. These Benefits are provided only if your Employer has selected Optional Preventive Benefits coverage. (Your Schedule of Benefits will show if Optional Preventive Benefits coverage is included).

Please note, the Benefit percentage will vary based on the Provider you choose. By using a Preferred Blue® Provider, you receive a higher Benefit percentage. This helps lower your Coinsurance — an amount you spend out of your own pocket.

Except for any services shown in your Schedule of Benefits, there is a limit to the amount of Coinsurance you must pay each Benefit Period for Preferred Blue Providers and All Other Providers. This is called your **Out-of-pocket Maximum**. It protects you from having to spend large sums of your own money on health care. Once you reach the Out-of-pocket Maximum if shown in your Schedule of Benefits, claims for covered services are paid at the amount shown in the Out-of-pocket Expenses section of your Schedule of Benefits for the rest of the Benefit Period except for any services shown in your Schedule of Benefits.

Important Things to Remember About Your Coverage

As mentioned earlier, this plan gives you the freedom to choose where you receive health care services — whether it's a trusted family Physician or a favorite local Hospital. What's important to remember is we pay your Benefits at a higher percentage when you receive medical, surgical, Mental Health Services or Substance Abuse care from a Preferred Blue Provider. This can easily add up to major savings for you. The section on Preferred Blue Providers will give you a better understanding.

To make sure you receive Medically Necessary services, this plan has built-in cost saving features that also control unnecessary costs. These cost saving features require that you file a Pre-service Claim to get Approval from us on certain services, Hospital visits, supplies and equipment. That way we can help you identify things that you can have done in a more affordable way and point out other things that you may not necessarily need. To avoid having your Benefits reduced or not paid at all, please get all necessary Approvals as outlined in this booklet. **Approval of a Pre-service Claim, however, is not a guarantee that we'll pay Benefits**. To make sure you get the most Benefits from this plan, please read the section, *Getting Approval from Blue Cross*. This section explains exactly when and how to get Approval.

If you have any questions about your coverage, please write or call our Member Service Center. You can find the address and telephone numbers in the section – *How to Contact Us if You Have a Question* .

Preauthorization for Mental Health Services and Substance Abuse care in the *Getting Approval from Blue Cross* section is modified by the revision of the following. The revision should not be construed as a complete replacement of the section:

Getting Approval from Blue Cross

Preauthorization for Mental Health Services and Substance Abuse care – Companion Benefit Alternatives, Inc. (CBA) must preapprove any inpatient or outpatient treatment for Mental Health Services and Substance Abuse care. On behalf of Blue Cross and Blue Shield of South Carolina, Companion Benefit Alternatives, Inc. (CBA) preauthorizes Mental Health Services and Substance Abuse care. Companion Benefit Alternatives, Inc. is a separate company that preauthorizes behavioral health benefits.

When Approval isn't obtained for inpatient Mental Health Services and Substance Abuse care, we'll deny covered charges for room and board. If a Preferred Blue Hospital doesn't get Approval for you, it can't bill you for room and board charges. When When Approval isn't obtained for outpatient or office Mental Health Services and Substance Abuse care, we'll reduce Benefits as shown in your Schedule of Benefits. If a Preferred Blue Provider doesn't get Approval for you, it can't bill you for the reduction. An All Other Provider, however, can bill you for the penalty.

The *Definitions* section is modified by the revision of the following. The revisions should not be construed as a complete replacement of the section:

Coinsurance: The percentage of Allowable Charge you pay as your share of the Covered Expenses. This percentage applies to the negotiated rate or lesser charge when we have negotiated rates with that Provider. Coinsurance amounts apply to the Out-of-pocket Maximum as shown in your Schedule of Benefits.

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

The term "Hospital" does not include long-term, chronic-care institutions or institutions that are, other than incidentally:
1. Convalescent, rest or nursing homes or facilities; or
2. Facilities primarily affording custodial, educational or rehabilitory care; or
3. For the treatment of substance or alcohol abuse; or
4. For the treatment of mental conditions.

A Hospital does not include a long-term, chronic-care institution or Facility that mainly provides care for items 1- 4 above, whether or not such institution or Facility is affiliated with or part of a Hospital.

Mental Health Services: The treatment of mental conditions. These conditions are defined, described or classified as psychiatric disorders or conditions in the latest publication of The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* . As used in the health plan, this does not include services for the treatment of Substance Abuse.

Out-of-pocket Maximum: The maximum amount of Coinsurance for Covered Expenses you will have to pay during a Benefit Period for certain services as shown in the Schedule of Benefits.

Coinsurance on certain services shown in the Summary of Benefits does not apply toward your Out-of-pocket Maximums. These services will be paid as shown in your Schedule of Benefits regardless of Out-of-pocket Maximums.

Certain other expenses also do not qualify toward your Out-of-pocket Maximums. They include the difference in an All Other Provider's fee and our Allowed Charge, the Deductible, Copayments and charges for non-covered services by any Provider.

Substance Abuse: The continued use, abuse and/or dependence of legal or illegal substance(s), despite significant consequences or marked problems associated with the use as defined, described or classified in the latest publication of The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* . As used in your health plan, this does not include services for treatment of Mental Health Services.

The *Covered Expenses* section is modified by the revision of the following. The revision should not be construed as a complete replacement of the section:

Mental Health Services – We'll provide Benefits as shown in your Schedule of Benefits. To avoid having to pay for these services yourself, be sure to get Preauthorization from Companion Benefit Alternatives, Inc. See the Getting Approval from Blue Cross section for more details.

Substance Abuse – We'll provide Benefits as shown in your Schedule of Benefits. To avoid having to pay for these services yourself, be sure to get Preauthorization from Companion Benefit Alternatives, Inc. See the Getting Approval from Blue Cross section for more details.

The *Exclusions and Limitations* section is modified by the revision of the following. The revisions should not be construed as a complete replacement of the section:

- Sanitarium care or rest cures; long-term, residential care for the treatment of Mental Health Services or Substance Abuse care, to include: residential treatment centers, therapeutic schools, wilderness/boot camps, therapeutic boarding homes, half-way houses and therapeutic group homes; and custodial care or domiciliary care (care meant simply to help those who can't care for themselves, such as, but not limited to, help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diet and supervision of medications which can usually be self-administered and which does not require continuous attention of trained Medical Personnel).
- Recreational, educational or play therapy; biofeedback; psychological or educational diagnostic testing to determine job or occupational placement, school placement or for other educational purposes, or to determine if a learning disorder exists; therapy for learning disorders, developmental speech delay, communication disorder, developmental coordination disorder, mental retardation, dissociative disorder, sexual and gender identity disorder, personality disorder and vocational rehabilitation unless specifically included in your Schedule of Benefits.
- Marriage or family counseling for premarital, marital or family relationship dysfunctions.

The *Exclusions and Limitations* section is modified by the addition of the following. The revision should not be construed as a complete replacement of the section:

- Counseling and psychotherapy services for: feeding and eating disorders in early childhood and infancy; tic disorder except for Tourette's disorder; elimination disorder; mental disorders due to general medical conditions; sexual function disorder; sleep disorder; medication induced movement disorder; and nicotine dependence unless specifically covered in this Contract.

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BLUE RX℠ BOOKLET INSERT

(The following additions/revisions should not be construed as a complete replacement of the sections in your Benefit Booklet unless otherwise noted.)

This supplement to your Benefit Booklet is effective for new and renewal groups on or after September 1, 2009.

Blue Rx under *Optional Prescription Drug Coverage* has been deleted in its entirety and replaced with the following:

Blue Rx

When your Physician prescribes medication, you can have it filled at any pharmacy. When you have your prescriptions filled at a Participating Network Pharmacy, however, you will enjoy a higher Benefit percentage and spend less of your own money.

When you buy your Prescription Drugs from a Participating Network Pharmacy, show the pharmacist your ID card. That way the pharmacist will know not to charge you more than the Allowed Charge. You can find a list of Participating Network Pharmacies in your Pharmacy Benefit Manager directory, or go to our online Provider directory at www.SouthCarolinaBlues.com.

Not all pharmacies are part of this network. If Benefits are available, Non-Participating Network Pharmacies can charge you more than your coverage allows — an amount you will then have to pay yourself. Benefits for drugs and supplies purchased from a non-Participating Network Pharmacy are also paid at a lower percentage. Please refer to your Schedule of Benefits to see if you have this Benefit. This increases your share of the cost even more.

If you buy your Prescription Drugs from a Participating Network Pharmacy or our Participating Mail-service Pharmacy, you will have no claims to file. Your claim will automatically be filed by the Pharmacy when you get your prescription filled. If you have met your Deductible, you only have to pay your Coinsurance amount for covered drugs. If you have not met your Deductible yet, you have to pay the Allowed Charge for Prescription Drugs that will be applied towards your Deductible.

If you buy your Prescription Drugs from a non-Participating Network Pharmacy (if Benefits are provided), you must pay for your drugs at the time your prescriptions are filled. You will then have to file your Prescription Drug claim.

To file a Prescription Drug claim:

- Use a Prescription Drug Rx claim form. To receive a form, call or write to the Member Service Center or you can get one from our Web site at www.SouthCarolinaBlues.com.
- Fill out the top half of the claim form.
- Sign the claim form.
- Attach a copy of all itemized Pharmacy receipts.
- Mail your claim and copy of receipts to the address shown on the form.

Be sure to follow these instructions very closely. Complete all paperwork so your claim can be processed. Then, we'll reimburse you directly at the maximum allowance for covered drugs shown in your Schedule of Benefits after the Deductible is met. We don't assign or pay Benefits directly to the Pharmacy.

To file a claim for medical supplies, use the Comprehensive Benefits Claim Form. Please refer to the *How to File Claims* section for information on completing this form.

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PRESCRIPTION AMENDMENT

This Amendment is subject to all provisions of the Contract between the Employer and the Corporation, which are not otherwise specified in the provisions of this Amendment.

This Amendment is effective for new and renewal groups on or after May 1, 2009.

ARTICLE I – DEFINITIONS, is amended by the deletion of paragraph 72. and the following substituted therefore:

72. **Prescription Drug:** A drug that has been approved by the FDA and labeled "Caution: Federal Law Prohibits Dispensing Without Prescription," or labeled in a similar manner. Only a licensed registered pharmacist can dispense it according to a Physician's prescription order. Injectable insulin is also included.
    a. **Brand-name Drug:** A Brand-name Drug may be a Preferred Drug or a Non-preferred Drug.
    b. **Generic Drug:** A Prescription Drug that normally has the same active ingredients as the Brand-name Drug but is not manufactured under a registered brand name or trademark.
    c. **Non-preferred Drug:** A Prescription Drug that has not been chosen by the Corporation, or its designated Pharmacy Benefit Manager, to be a Preferred Drug. This includes any Brand-name Drug with an "A" rated Generic Drug available.
    d. **Preferred Drug:** A Prescription Drug that has been reviewed for cost, clinical effectiveness and quality. The Preferred Drug List is subject to periodic review and updates by the Corporation, or its designated Pharmacy Benefit Manager, without prior notice.

    Specific classes of Over-the-counter Drugs may be covered as Prescription Drugs. If so designated and the Schedule of Benefits reflects Benefits are available, these classes of Over-the-counter Drugs must have a valid prescription.

ARTICLE III – COVERED SERVICES, is amended by the deletion of paragraph 3.w. and the following substituted therefore:

3.w. **Prescription Drugs** – As specified in the Schedule of Benefits. Insulin will be treated as a Prescription Drug whether injectable or otherwise.

Specialty Drugs are covered only as specified in the Schedule of Benefits.

Specific classes of Over-the-counter Drugs designated by the Corporation, or its designated Pharmacy Benefit Manager, may be covered as Prescription Drugs. The Corporation will allow coverage for specific Over-the-counter Drugs only when use of Over-the-counter Drugs are required as part of a step therapy program. If so designated and the Schedule of Benefits reflects Benefits are available, these classes of Over-the-counter Drugs must have a valid prescription.

The Corporation receives financial credits directly from drug manufacturers and through a Pharmacy Benefit Manager (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 an Employee 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 the Corporation. Copayments are flat amounts and likewise do not change due to receipt of drug manufacturer or PBM credits.

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ARTICLE V – EXCLUSIONS AND LIMITATIONS, is amended by the deletion of paragraph 1.ao. and the following substituted therefore:

1.ao. Drugs for which there is an Over-the-counter (OTC) Drug equal to it except for Over-the-counter Drugs considered to be Prescription Drugs if specified in the Schedule of Benefits. Any OTC supplies or supplements.

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PRESCRIPTION BOOKLET INSERT

(The following additions/revisions should not be construed as a complete replacement of the sections in your Benefit Booklet unless otherwise noted.)

This supplement to your Benefit Booklet is effective for new and renewal groups on or after May 1, 2009.

The *Definitions* section is modified by the revision of the following definition. The revision should not be construed as a complete replacement of the section:

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

- **Brand-name Drug:** A Brand-name Drug may be a Preferred Drug or a Non-preferred Drug.
- **Generic Drug:** A Prescription Drug that normally has the same active ingredients as the Brand-name Drug but is not manufactured under a registered brand name or trademark.
- **Non-preferred Drug:** A Prescription Drug that has not been chosen by the Corporation, or its designated Pharmacy Benefit Manager, to be a Preferred Drug. This includes any Brand-name Drug with an "A" rated Generic Drug available.
- **Preferred Drug:** A Prescription Drug that has been reviewed for cost, clinical effectiveness and quality. The Preferred Drug List is subject to periodic review and updates by the Blue Cross, or its designated Pharmacy Benefit Manager, without prior notice.

Specific classes of Over-the-counter Drugs may be covered as Prescription Drugs. If so designated and the Schedule of Benefits reflects Benefits are available, these classes of Over-the-counter Drugs must have a valid prescription.

The *Covered Expenses* section is modified by the revision of the following. The revision should not be construed as a complete replacement of the section:

Prescription Drugs – We'll provide Benefits as shown in your Schedule of Benefits.

We'll treat insulin as a Prescription Drug whether it's injectable or otherwise.

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

Specific classes of Over-the-counter Drugs designated by Blue Cross, or its designated Pharmacy Benefit Manager, may be covered as Prescription Drugs. We will allow coverage for specific Over-the-counter Drugs only when use of Over-the-counter Drugs are required as part of a step therapy program. If so designated and your Schedule of Benefits reflects Benefits are available, these classes of Over-the-counter Drugs must have a valid prescription.

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The Pharmacy Benefit Manager (PBM) for Blue Cross and some of its subsidiaries, contracts with and manages the Pharmacy network, negotiates prices with Pharmacies in the network 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. It does not change when we receive any financial credit. Copayments are flat amounts and likewise do not change when we receive drug manufacturer or PBM credits.

The *Exclusions and Limitations* section is modified by the revision of the following exclusion. The revision should not be construed as a complete replacement of the section:

Prescription Drugs for which there is an Over-the-counter (OTC) Drug equal to it except for Over-the-counter Drugs considered to be Prescription Drugs if shown in your Schedule of Benefits. Any OTC supplies or supplements.

Facts About Medicare Prescription Drug Plans 2013

What are Medicare prescription drug plans?
Since January 1, 2006, insurance companies and other private companies have been offering Medicare-eligible people new Medicare prescription drug plans with negotiated discounts on drug prices. These plans are not the Medicare-approved drug discount cards that were phased out May 15, 2006.

Medicare prescription drug plans provide insurance coverage for prescription drugs. Like other insurance, if you join you will pay a monthly Part D premium (in addition to your Part B premium) and pay a share of the cost of your prescriptions. Costs will vary depending on the drug plan you choose.

Drug plans may vary in what prescription drugs are covered, how much you will pay, and which pharmacies you can use. Most plans will have a formulary, which is a list of drugs covered by the plan. This list must always meet Medicare's requirements, but it can change when plans get new information. Your plan must let you know at least 60 days before a drug you use is removed from the list or if the costs are changing. If your doctor thinks you need a drug that isn't on the list, or if one of your drugs is being removed from the list, you or your doctor can apply for an exception or appeal the decision.

What will be paid for under a Medicare prescription drug plan?
When you get Medicare prescription drug coverage, you will pay a premium each month to join the drug plan. If you have Medicare Part B, you also pay your monthly Part B premium. If you belong to a Medicare Advantage plan or Medicare Cost plan, the monthly premium you pay to the plan may increase if you add prescription drug coverage. Your plan must, at a minimum, provide a standard level of coverage as shown below. Some plans offer more coverage or lower premiums. Your costs will vary depending on which plan you choose.

<u>For Standard Coverage (the minimum coverage drug plans must provide)</u>

If you join in 2013, for covered drugs you will pay:

- A monthly premium (varies depending on the plan you choose)

  You pay a copayment or coinsurance and the plan pays its share for each covered drug until total payment reaches $2,970.

Once you and your plan have spent $2,970 for covered drugs:

- You pay 47.5 percent of the costs of name-brand drugs, including a dispensing fee.
- You pay 79 percent of the costs of generic drugs, until your out-of-pocket costs for the year reach $4,750.

After your out-of-pocket drug costs reach $4,750, you pay the greater of:

- $2.65 copayment for a generic drug (including name-brand drugs treated as generic) or $6.60 copayment for any other drug, OR
- 5 percent coinsurance

When can I join a Medicare prescription drug plan?
Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15 through December 7. Your coverage will be effective the first day of the month after the month you join. Even if you don't use a lot of prescription drugs now, you should consider joining a plan. If you don't join a plan when you are eligible, and you don't have a drug plan that covers as much or more than a Medicare prescription drug plan, you will have to pay more each month to join later.

What if I can't pay for a Medicare prescription drug plan?
Some people with an income at or below a set amount and with limited assets (including your savings and stocks, but not counting your home) will qualify for extra help. The type of extra help will be based on your income and assets. If you think you qualify for extra help, you can sign up with the Social Security Administration or your local Medicaid office.

Do Medicare prescription drug plans work with all types of Medicare health plans?
Yes. There will be Medicare prescription drug plans that add coverage to the original Medicare plan and private fee-for-service plans. Insurance companies and other private companies offer these plans. There are also other drug plans that are a part of Medicare Advantage plans (like HMOs) in some areas.

What if I already have prescription drug coverage?
If you have prescription drug coverage, either through an individual policy or through a group from an employer or union, you will get a notice that tells you whether that coverage is creditable or not. It is creditable coverage if your plan covers as much or more than a Medicare prescription drug plan.

If your current plan covers as much as or more than a Medicare prescription drug plan (it is creditable drug coverage), you can:

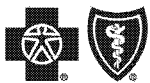
- Keep your current drug plan. If you join a Medicare prescription drug plan later your monthly premium won't be higher.
- Drop your current drug plan and join a Medicare prescription drug plan, but you may not be able to get your current drug plan back.

If your current plan covers less than a Medicare prescription drug plan (it is NOT creditable drug coverage), you can:

- Keep your current drug plan and join a Medicare prescription drug plan to give you more complete prescription drug coverage.
- Just keep your current drug plan. But, if you join a Medicare prescription drug plan later, you will have to pay more for the monthly premium.
- Drop your current drug plan and join a Medicare prescription drug plan, but you may not be able to get your current drug plan back.

When will I get more information?
Medicare has begun to provide more information about Medicare prescription drug plans, including how to choose and join a drug plan that best meets your needs. The "Medicare & You" handbook lists the Medicare prescription drug plans available in your area.

How can I get help choosing a Medicare prescription drug plan?
You can get personalized information at the Medicare website (**Medicare.gov**) or by calling 800-MEDICARE (800-633-4227) to help you make your best choice. TTY users should call 877-486-2048. Your State Health Insurance Assistance Program and other local and community-based organizations will also provide you with free health insurance counseling.



South Carolina **GREATER COLUMBIA**

Coverage Period: 01/01/2018 - 12/31/2018 Coverage for: INDIVIDUAL-FAMILY | **Plan Type:** PPO

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-868-2500, Ext. 41000 to request a copy. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-800-868-2500, Ext. 41000 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$750 / person Limited to 3/family/benefit period Does not apply to preventive care, office charges and prescription drugs when a copay applies, and inpatient facility in-network. Deductible does not include Copays.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services and office visits are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the maximum out-of-pocket limit for this plan?	Yes; $1,500 person/$3,000 family for Preferred Blue® Providers. For all other providers $3,000 person/$6,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the maximum out-of-pocket limit?	Copays; deductibles; premiums; balance-billed charges; mental health/substance abuse or spinal subluxation (if purchased); coinsurance; health care this plan does not cover; and penalties for no prior approval.	Even though you pay these expenses, they don't count toward the maximum out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of Preferred Blue providers, see www.SouthCarolinaBlues.com or call 1-800-868-2500, ext. 41000.	This plan uses a provider network. You will pay less if you use a provider in plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
Do I need a referral to see a specialist?	No. You do not need a referral to see a specialist.	You can see the **specialist** you choose without a referral.

All **copayments** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations , Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	40% coinsurance	20% coinsurance for in-network office services such as: surgery, second surgical opinion, consultations, dialysis treatment, chemotherapy, radiation therapy, specialty drugs, endoscopies and imaging. Deductible does not apply if copay applies.
	Specialist visit	$35 copay/visit	40% coinsurance	20% coinsurance for in-network office services such as: surgery, second surgical opinion, consultations, dialysis treatment, chemotherapy, radiation therapy, specialty drugs, endoscopies and imaging. Deductible does not apply if copay applies.
	Preventive care/screening/immunization	No charge	Not covered	No charge for mammograms at a participating provider.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	NONE
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	No benefit if not preapproved.
If you need drugs to treat your illness or condition	Tier 1 Drugs	$8 copay/prescription (retail) $16 copay/prescription (mail order)	$8 copay/prescription (retail) and 40% coinsurance	Covers up to a 31-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Tier 2 Drugs	$30 copay/prescription (retail) $70 copay/prescription (mail order)	$30 copay/prescription (retail) and 40% coinsurance	Covers up to a 31-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Tier 3 Drugs	$60 copay/prescription (retail) $140 copay/prescription (mail order)	$60 copay/prescription (retail) and 40% coinsurance	Covers up to a 31-day supply (retail prescription); 31-90 day supply (mail order prescription)

Common Medical Event	Services You May Need	What You Will Pay		Limitations , Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
More information about **prescription drug coverage** is available at **www.SouthCarolinaBlues.com/links/metallic/pharmacy/BusinessBlueEssentials**	Tier 4 Drugs	10% copay/prescription (mail order)	Not covered	Covers up to a 31-day mail order supply at a Specialty Drug Network Provider No benefits if not preapproved $200/dose maximum copay
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	50% reduction of allowed amount if not pre-approved for hysterectomy or septoplasty.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	50% reduction of allowed amount if not pre-approved for hysterectomy or septoplasty.
If you need immediate medical attention	Emergency room services	20% coinsurance	Facility charges only - 20% coinsurance. All other charges - 40% coinsurance.	NONE
	Emergency medical transportation	20% coinsurance	40% coinsurance	NONE
	Urgent care	$25 /$35 copay/visit	40% coinsurance	20% coinsurance for in-network office services such as: surgery, second surgical opinion, consultations, dialysis treatment, chemotherapy, radiation therapy, specialty drugs, endoscopies and imaging. Deductible does not apply if copay applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Room and board denied if stay is not approved. $250/admission copay at an All Other Provider. No benefits for human organ/tissue transplant if not preapproved and at designated provider.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	No benefits for human organ/tissue transplant if not preapproved and at designated provider.

Common Medical Event	Services You May Need	What You Will Pay		Limitations , Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	20% coinsurance	40% coinsurance	50% reduction of allowed amount if not pre-approved. Limited to 25 outpatient/office visits per year for mental/behavioral and substance use combined.
	Inpatient services	20% coinsurance	40% coinsurance	Room and board denied if stay is not approved. Limited to 7 days per year for mental/behavioral and substance use combined. $250/admission copay at an All Other Provider.
If you are pregnant	Office Visits	20% coinsurance	40% coinsurance	For employee or spouse only. Cover screening for gestational diabetes and lactation support/counseling for dependent children.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	For employee or spouse only. Cover screening for gestational diabetes and lactation support/counseling for dependent children.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	For employee or spouse only. $250/admission copay at an All Other Provider.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 60 visits/year. No benefits if not preapproved.
	Rehabilitation services	20% coinsurance	40% coinsurance	No inpatient benefits if not preapproved and at designated provider. $250/admission copay at an All Other Provider. Outpatient/office physical therapy limited to 30 visits per year (speech/occupational therapy not covered).
	Habilitation services	Not covered	Not covered	NONE
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 60 days per year. Room and board denied if stay is not approved. $250/admission copay at an All Other Provider.

Common Medical Event	Services You May Need	What You Will Pay		Limitations , Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance	Not covered	Excludes repair of, replacement of and duplicate. No benefits if not preapproved when cost is $500 or more. Prosthetics is limited to $50,000/year.
	Hospice service	20% coinsurance	40% coinsurance	Limited to 6 months/episode. No benefits if not preapproved.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	NONE
	Children's glasses	Not covered	Not covered	NONE
	Children's dental check-up	Not covered	Not covered	NONE

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion*
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Eye exam (Child)
- Glasses (Child)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Other practitioner office visit
- Private duty nursing
- Residential and custodial care
- Routine eye care (Adult)
- Routine foot care
- Routine maternity care for dependent child
- TMJ and related conditions
- Varicose veins treatment
- Weight loss programs

*Abortion services (except in cases of rape, incest, or when the life of the mother is endangered)

Other Covered Services. (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Non-emergency care when traveling outside the U.S. See www.SouthCarolinaBlues.com/members/findaprovider.aspx

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The State Insurance Department, U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit http://www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the plan at 1-800-868-2500, Ext. 41000 or visit www.SouthCarolinaBlues.com, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, your state office of health insurance customer assistance at: 1-800-768-3467 or visit www.doi.sc.gov.

Does this Coverage Provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*For more information about limitations and exceptions, see the plan or policy document at www.SouthCarolinaBlues.com.

——————————To see examples of how this plan might cover costs for a sample medical situation, see the next section.——————————

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,610**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,200
Coinsurance	$30
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,390**

Mia's Simple Fracture (in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,150**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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.

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 online at contact@hrcompliance.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，請撥電話 [在此插入數字 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 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (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, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 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)