SCHEDULE OF BENEFITS FOR BUSINESS BLUE[SM] COMPLETE

Employer Name: SC CAMPAIGN TO PREVENT TEEN PREGNANCY
Client Number: 34918 Group Number: 05-57443-00
Client Effective Date: July 1, 2007 Coverage Effective Date: July 1, 2019
Anniversary Date: July 01
Benefit Period: July 1st thru June 30th

Deductible - You pay	$1500 each Benefit Period Limited to three Deductibles per Family. Does not apply to the Out-of-pocket Expense.
Copayment - You pay	$35 Primary Care Physician (PCP) office visit - a PCP is a family doctor, general Physician, OB-GYN, pediatrician, osteopath or internal medicine Physician $60 Specialist 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 - $2000 per Member or $4000 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 Mental Health Services, Substance Abuse care and Spinal Subluxation Services (if purchased). All Other Providers - $4000 per Member or $8000 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 Mental Health Services, Substance Abuse care and Spinal Subluxation Services (if purchased). Out-of-pocket Covered Expenses contribute to both Out-of-pocket Maximums. Coinsurance for Mental Health Services, Substance Abuse care and 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: 30 visits for physical therapy, other than inpatient 7 Inpatient days for Mental Health Services/Substance Abuse care 25 Outpatient/office visits for Mental Health Services/Substance Abuse care (combined office, outpatient Facility and Physician) 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 outpatient services require Preauthorization Review: covered Mental Health Services and covered Substance Abuse care, 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 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.

	WE PAY CONTRACTING MAIL SERVICE PHARMACY	**WE PAY PARTICIPATING NETWORK PHARMACIES**	**WE PAY NON-PARTICIPATING NETWORK PHARMACIES**
Prescription Drugs			
Drug Card 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.	50% 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	70% after the Deductible	50% 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	50% 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	70% after the Deductible	50% after the Deductible
Endoscopies (such as proctoscopy and laparoscopy) performed in a Physician's office, whether for diagnosis or treatment	70% after the Deductible	50% 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	70% after the Deductible	50% 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)	Not Purchased	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)	70% after the Deductible	50% 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)	70% after the Deductible	50% after the Deductible
Home Health Care and Hospice Care with the required Preauthorization	70% after the Deductible	50% after the Deductible
Physical therapy (limited to 30 visits per Benefit Period, other than inpatient)	70% after the Deductible	50% 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.	70% after the Deductible	50% 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%	50% 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%	50% after the Deductible
All other covered contraceptive devices or services not specifically listed	70% after the Deductible	50% after the Deductible
Mental Health Services/Substance Abuse Benefits Combined		
Inpatient Facility charges (limited to 7 days per Benefit Period, combined Facility/Physician)	70%	50% after the Copayment and the Deductible
Inpatient Physician charges (limited to 7 days per Benefit Period, combined Facility/Physician)	70% after the Deductible	50% after the Deductible
Outpatient Facility/Clinic charges (limited to 25 visits per Benefit Period, combined all outpatient/office charges)	70% after the Deductible	50% after the Deductible
Outpatient/office Physician charges (limited to 25 visits per Benefit Period, combined Facility/Physician)	70% after the Deductible	50% after the Deductible
Emergency Room charges (limited to 25 visits per Benefit Period, combined with outpatient/office charges)	70% after the Deductible	50% after the Deductible

	WE PAY PREFERRED BLUE PROVIDERS	**WE PAY 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	70%	50% after the Copayment and the Deductible
Inpatient Rehabilitation services (must be Preauthorized by the Corporation and performed at a Designated Provider)	70%	50% 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	70% after the Deductible	50% 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

BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA

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

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.

BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA

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

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.

BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA

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

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.

BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA
(An Independent Licensee of the Blue Cross and Blue Shield Association,
an association of independent Blue Cross and Blue Shield Plans)
(www.SouthCarolinasBlues.com)

James A. Deyling
President
Blue Cross and Blue Shield 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.)
www.SouthCarolinaBlues.com

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.

BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA
(An Independent Licensee of the Blue Cross and Blue Shield Association,
an association of independent Blue Cross and Blue Shield Plans)
(www.SouthCarolinasBlues.com)

James A. Deyling
President
Blue Cross and Blue Shield 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.)
www.SouthCarolinaBlues.com

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.

BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA
(An Independent Licensee of the Blue Cross and Blue Shield Association,
an association of independent Blue Cross and Blue Shield Plans)
(www.SouthCarolinasBlues.com)

James A. Deyling
President
Blue Cross and Blue Shield 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.)
www.SouthCarolinaBlues.com

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.

BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA
(An Independent Licensee of the Blue Cross and Blue Shield Association,
an association of independent Blue Cross and Blue Shield Plans)
(www.SouthCarolinasBlues.com)

James A. Deyling
President
Blue Cross and Blue Shield 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.)
www.SouthCarolinaBlues.com

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.

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.

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.

BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA
(An Independent Licensee of the Blue Cross and Blue Shield Association,
an association of independent Blue Cross and Blue Shield Plans)
(www.SouthCarolinasBlues.com)

James A. Deyling
President
Blue Cross and Blue Shield 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.)
www.SouthCarolinaBlues.com

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.

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.