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 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.
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 Carolina Preferred Plan Coverage Works section is modified by the revision of the following:

How Your Carolina Preferred Plan Coverage Works

To better understand how your Carolina Preferred Plan 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 Carolina Preferred Plan 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 lifetime basis. This plan, like other insurance plans, has limits on the amount payable during a Benefit Period and during the lifetime 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 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, the Carolina Preferred 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, the Carolina Preferred 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, 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.
Preauthorization for Mental Health Services and Substance Abuse care in the 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:

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 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 Out-of-pocket Maximums section is modified by the revision of the following. The revision should not be construed as a complete replacement of the section:

Out-of-pocket Maximums

When you have reached the Preferred Blue network Out-of-pocket Maximum, we’ll pay the amount shown in the Out-of-pocket Expenses section of your Schedule of Benefits for covered services provided from Preferred Blue Providers for the rest of the Benefit Period except for certain services shown in the Schedule of Benefits. This is an important benefit because it saves you money.

There is a separate, possibly higher, Out-of-pocket Maximum for services by Non-preferred Blue Providers. When you have reached this limit, we’ll pay the amount shown in the Out-of-pocket Expenses section of your Schedule of Benefits for covered services provided by Non-preferred Blue Providers for the rest of the Benefit Period except for certain services shown in the Schedule of Benefits.

Out-of-pocket Covered Expenses contribute to both Out-of-pocket Maximums.

Coinsurance on certain services shown in the Schedule 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 a Non-preferred Blue Provider’s fee and our Allowed Charge, the Deductible, Copayments and charges for non-covered services by Preferred Blue and Non-preferred Blue Providers.

You will receive an Explanation of Benefits (EOB) explaining payments made for your health claims. The EOB also shows any amount that was applied to your Out-of-pocket Maximum.

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.
Investigational or Experimental Services: The use of services or supplies that Blue Cross doesn’t recognize as standard medical care for the treatment of conditions, diseases, illnesses or injuries. These include but aren’t limited to, treatments, procedures, facilities, equipment, drugs or devices. Here are the criteria used to base our decision on whether a service or supply is Investigational or Experimental:

1. Services or supplies requiring Federal or other governmental agency approval such as drugs and devices that have restricted market approval from the Food and Drug Administration (FDA) or from any other governmental regulatory agency for the use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.

   We will, however, allow coverage for a Prescription Drug that hasn’t been approved by the FDA:
   a. For a specific medical condition when there are at least two formal clinical studies recognizing the use of the drug for the medical condition; or
   b. For the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one standard reference compendium or the drug is found to be safe and effective in formal clinical studies. These results must have been published in peer-reviewed professional medical journals.

2. There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to let Blue Cross evaluate the therapeutic value of the service or supply.

3. There is inconclusive evidence that the service or supply has a beneficial effect on a person’s health.

4. The service or supply under consideration is not as beneficial as any established alternatives.

5. There is insufficient information or inconclusive scientific evidence that the service or supply is beneficial to a person’s health and is as beneficial as any established alternatives when it’s used in a non-investigational setting.

If a service or supply meets one or more of these criteria, it is Investigational or Experimental. Blue Cross solely makes these determinations after independent review of scientific data. We may consider opinions of professionals in a particular field and/or opinions and assessments of nationally recognized review organizations, but they are not determinative or conclusive.

Blue Cross’ Medical Director, in making such determinations, may use one or more of these sources of information:

1. FDA-approved market rulings
2. The United States Pharmacopoeia and National Formulary
3. The annotated publication titled, Drugs, Facts and Comparisons, published by J.B. Lippincott Company
4. Available peer-reviewed literature
5. Appropriate consultation with specialists on a local and national level

Medically Necessary: Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease;
3. Not primarily for the convenience of the patient, Physician, or other health care Provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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.

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

Full-time Student: A Dependent child age 22 or younger and enrolled in and attending one of these:
1. High school; or
2. An accredited or licensed school commonly recognized as a vocational, technical or trade school with attendance qualifying the Dependent child as a full-time student under the rules of the institution; or
3. A college or university with full enrollment in at least enough regular academic courses to reach the status of a full-time student at the institution.

Periods between school terms, such as summer periods, will be included if the Dependent child was attending as a Full-time Student during the last regular school term session. Correspondence-course participation doesn’t count as attendance as a Full-time Student for items 1 – 3 above.

A time period between graduation from high school and vocational, technical or trade school or college entry, or between college graduation and graduate school entry, will be included only if the Dependent child has applied for admission beginning with the next regular school term immediately following graduation.

If the child is a Full-time Student, notify us in writing. For your child to be covered under your Contract as a student Dependent:
• Your letter must state your child is a Full-time Student and be signed by you.
• The letter also must include a tuition receipt from the school’s Bursar’s office or a letter from the school verifying its accreditation and student’s full-time status.
• This information must be given to Blue Cross (addressed to the Member Service Center) at least yearly for the child’s student Dependent status to continue. In addition, if a claim is received and we haven’t been notified, you will receive a notice stating the claim has been denied or that we need information to complete processing the claim. For us to update your files, return the notice with the above-required information.

A Dependent child who is a Full-time Student on the day prior to beginning a Medically Necessary Leave of Absence may remain covered under this group health plan until the earlier of: 1) one year from the first day of the Medically Necessary Leave of Absence; or 2) the date on which the coverage would otherwise terminate under the Contract.

A Dependent child must enroll as a Full-time Student the next regular term following the end of a Medically Necessary Leave of Absence to remain classified as a Full-time Student.

The Definitions section is modified by the addition of the following definition:

Medically Necessary Leave of Absence – Occurs when a Full-time Student stops attending school, or drops to part-time attendance, due to a serious illness or injury that prevents full-time attendance. We must receive documentation from the Full-time Student’s treating Physician certifying that he or she is suffering from a serious illness or injury and that the leave of absence is Medically Necessary.
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.
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 July 1, 2008.

The How to Contact Us section is modified by the revision of Pre-service Claims and Reviews under How to Get Help. The revision should not be construed as a complete replacement of the section.

Pre-service Claims and Reviews

Certain health care services shown in your Schedule of Benefits require a Pre-service Claims review or authorization before you receive services. If you receive any of the referenced services, please call:

- 803-736-5990 (from the Columbia area)
- 1-800-327-3238 (from all other South Carolina locations)
- 1-800-334-7287 (from outside South Carolina)

For Preadmission Review and Preauthorization of Mental Health Services and Substance Abuse care, call Companion Benefit Alternatives, Inc. (CBA) at:

- 803-699-7308 (from the Columbia area)
- 1-800-868-1032 (from all other areas)

On behalf of Blue Cross, Companion Benefit Alternatives, Inc. preauthorizes Mental Health Services and Substance Abuse services. Companion Benefit Alternatives, Inc. is a separate company that preauthorizes behavioral health benefits.

Whenever you call us, please have your Blue Cross ID card handy. Our Member Services representative will ask for the ID number on the front of your card. When writing to us, please include your name, address, ID number and phone number in the letter. We recommend you keep your card with you at all times because you never know when you may need to contact us.

The Approval from Blue Cross section is modified by the revision of the following paragraph. The revision should not be construed as a complete replacement of the section.

To make the most of your Benefits, Blue Cross has an Approval process in place. Medical Services personnel (a group of medical professionals employed by us) must give advance Approval for Pre-service Claims, which include all Hospital Admissions and certain other specified services for you to receive maximum Benefits (see the section on Preauthorization Review). Their responsibility is to review all requests for prior Approval. Inpatient and outpatient services you receive for treatment of Mental Health Services and Substance Abuse care require Preauthorization by Companion Benefit Alternatives, Inc. (CBA).
The Definitions section is modified by the revision of the following definitions:

Investigational or Experimental Services: The use of services or supplies that Blue Cross doesn’t recognize as standard medical care for the treatment of conditions, diseases, illnesses or injuries. These include, but aren’t limited to: treatments, procedures, facilities, equipment, drugs or devices. Here are the criteria used to base our decision on whether a service or supply is Investigational or Experimental:

1. Services or supplies requiring Federal or other governmental agency approval, such as drugs and devices that have restricted market approval from the Food and Drug Administration (FDA) or from any other governmental regulatory agency for the use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.

   We will however, allow coverage for a Prescription Drug that hasn’t been approved by the FDA:
   a. For a specific medical condition when there are at least two formal clinical studies recognizing the use of the drug for the medical condition; or
   b. For the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one standard reference compendium or the drug is found to be safe and effective in formal clinical studies. These results must have been published in peer-reviewed professional medical journals.

2. There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to let the Corporation evaluate the therapeutic value of the service or supply.

3. There is inconclusive evidence that the service or supply has a beneficial effect on a person’s health.

4. The service or supply under consideration is not as beneficial as any established alternatives.

5. There is insufficient information or inconclusive scientific evidence that the service or supply is beneficial to a person’s health and is as beneficial as any established alternatives when used in a noninvestigational setting.

If a service or supply meets one or more of these criteria, it is Investigational or Experimental. The Corporation solely makes the determinations after independent review of scientific data. The Corporation may also consider opinions of professionals in a particular field and/or opinions and assessments of nationally recognized review organizations, but they are not determinative, nor conclusive.

The Corporation’s Medical Director, in making such determinations, may use one or more of these sources of information:

1. FDA-approved market rulings
2. The United States Pharmacopoeia and National Formulary
3. The American Medical Association’s Drug Evaluation publications
4. The annotated publication titled, Drugs, Facts, and Comparisons, published by J. B. Lippincott Company
5. Available peer review literature
6. Appropriate consultation with specialists on a local and national level

Medically Necessary or Medical Necessity: Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease;
3. Not primarily for the convenience of the patient, Physician, or other health care Provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.
The Definitions section is modified by the addition of the following definitions:

**Autism Spectrum Disorder:** Autistic Disorder, Asperger’s Syndrome and Pervasive Developmental Disorder.

**Behavioral Therapy:** Behavioral modification using applied behavioral analysis (ABA) techniques to target cognition, language and social skills.

Behavioral Therapy does not include educational or alternative programs such as, but not limited to:

1. TEAACH
2. Auditory integration therapy
3. Higashi schools/daily life
4. Facilitated communication
5. Floor time (DIR, developmental individual-difference relationship-based model)
6. Relationship development intervention (RDI), holding therapy
7. Movement therapies
8. Music therapy
9. Pet therapy

**Provider:** Any of the following: a Facility, Hospital, Skilled Nursing Facility, Rehabilitation Facility, mental health or Substance Abuse Facility, Physician, psychologist, other mental health clinicians (when preauthorized) and Ambulatory Surgical Center licensed as required by the state where located or legally engaged, performing within the scope of the license and acceptable to us or as listed:

1. Durable Medical Equipment suppliers
2. Independent clinical laboratory
3. Occupational, physical and speech therapist
4. Pharmacy
5. Home Health Care supplier
6. Hospice Care supplier
7. Behavioral health

The Covered Expenses section is modified by the addition of the following:

**Autism Spectrum Disorder** – If specified in the Schedule of Benefits. Limited to treatment prescribed by the treating Physician according to a treatment plan. The treatment plan must include all necessary elements such as, but not limited to, a diagnosis, proposed treatment by type, frequency, and duration of treatment, anticipated outcomes stated as goals, the frequency by which the treatment plan will be updated and the treating Physician’s signature. Benefits are limited to services rendered by a covered Provider. The child must be diagnosed at age 8 or younger and Benefits end when the child turns 16.

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:

Recreational, educational or play therapy; bio-feedback or psychological testing to determine if a learning disability or behavior disorder exists; therapy for learning disabilities and communication delay, perceptual disorders, behavioral disorders, mental retardation and vocational rehabilitation unless specifically included in the Schedule of Benefits.
SPECIALTY DRUGS 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 November 1, 2007.

The Definitions section is modified by the addition of the following definitions:

Dose: An approved quantity for a prescription or refill or single treatment of a Specialty Drug. No Dose may exceed a 31-day supply.

Specialty Drugs: FDA approved Prescription Drugs that treat a complex clinical condition and/or require special handling such as refrigeration. They normally require unusual/complex clinical monitoring and special training. Specialty Drugs include but are not limited to infusible specialty drugs for acute and chronic diseases, injectable and self-injectable drugs for acute and chronic diseases, biotechnology medicines and specialty oral drugs or other dosage forms.

Specialty Drug Copayment: The amount payable (if any) by you for each Specialty Drug, as shown in your Schedule of Benefits. The Specialty Drug Copayment doesn’t apply to the Deductible or the Out-of-pocket Maximum shown in your Schedule of Benefits and will continue to apply even after your Out-of-pocket Maximum is met.

Specialty Drug Network Provider: A Provider that has a written agreement to participate in a special pharmaceutical network with the Corporation to provide Specialty Drugs. A Specialty Drug Network Provider also agrees to accept the Corporation’s allowance as payment in full for Covered Expenses except for any Deductibles, Copayments and Coinsurance you may owe. A Specialty Drug Network Provider may be different from a Preferred Blue Provider.

The Covered Expenses section is modified by the addition of the following paragraph under Prescription Drugs. The revision should not be construed as a complete replacement of the noted benefit.

Specialty Drugs are not covered under this Benefit.

The Covered Expenses section is modified by the addition of the following benefit.

Specialty Drugs – A Physician must prescribe Specialty Drugs. The prescription must be filled by a Specialty Drug Network Provider. Benefits for covered Specialty Drugs dispensed to you shall not exceed the quantity and benefit maximum, if any, as shown in your Schedule of Benefits. Please contact the Member Services Center at the phone number listed in the How to Contact Us section to see if a specific drug is a Specialty Drug or you can get the list from our Web site at www.SouthCarolinaBlues.com. Preauthorization is required for Benefits to be available.

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 Specialty Drug Network Providers, or discounted prices charged by Specialty Drug Network Providers, are not affected by these credits. Any Coinsurance percentage that an Employee must pay for Specialty Drugs is based on the negotiated rate or lesser charge at the Specialty Drug Network Provider, 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.

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

- Any Prescription Drug or Specialty Drug that is not consistent with the diagnosis and treatment of an illness, injury or condition or that is excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care.

Spec. Drug bk – Smgrp (8/07)
The following revisions should not be construed as a complete replacement of the sections in your Benefit Booklet unless otherwise noted.

This is a supplement to your Benefit Booklet and is effective for new and renewal groups on or after July 1, 2005.

The Pre-existing Condition Limitations section has been deleted in its entirety and replaced with the following:

“Pre-existing Condition(s)” are physical or mental conditions present before the Enrollment Date, whether or not any medical advice, diagnosis, care or treatment was received or recommended before that day.

Any services or charges for Pre-existing Conditions are not covered under the 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 Conditions Exclusion lasts until the earlier of:
1. The Member has not received medical care, treatment or supplies for the Pre-existing Condition for 12 months ending after the Effective Date of coverage; or
2. 12 months after the Enrollment Date.

In the case of a Late Enrollee, the Pre-existing Conditions Exclusion begins on the Enrollment Date and lasts for 18 months.

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 doesn’t count if there is at least a 63-day period where you or your Dependent was not covered under any Creditable Coverage.

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

The Pre-existing Condition Limitation does not apply to Routine Maternity or to Genetic Information when there has been no diagnosis of the condition related to the information.

The Pre-existing Condition Limitation does not apply to a newborn child, a child who is adopted or a child who is placed with you or your spouse for the purpose of adoption before he or she reaches age 18 if you applied for coverage and you paid your premiums within 31 days from the birth, adoption or placement for adoption.

The newborn and adoption provisions will no longer apply to you or your eligible Dependent after the end of the first 63-day period where you or your Dependent was not covered under any Creditable Coverage.

If you have single coverage and add Dependents, the Pre-existing Condition Limitations applies to any Dependents as of the Effective Date of the upgraded coverage unless there is Creditable Coverage.
The Definitions section has been modified by the revision of the following:

**Accidental Injury**: An injury directly and independently caused by a specific accidental contact with another body or object such as a car accident or blow by a moving object. All injuries you receive in one accident, including all related conditions and recurrent symptoms of these injuries, will be considered one injury. Accidental Injury doesn’t include indirect or direct loss that results in whole or partially from a disease or other illness.

**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 regulations;
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 Exempted Benefits.

We will count a period of Creditable Coverage without regard to specific health benefits covered during that time.

**Enrollment Date**: The date of enrollment in the Group Health Plan or the first day of the Waiting Period for enrollment, whichever is earlier.

**Pre-existing Condition(s)**: A physical or mental condition present before the Enrollment Date, whether or not any medical advice, diagnosis, care or treatment was received or recommended before that day.

The Covered Expenses section has been modified by the revision of the following:

**Prosthetic Devices** – Artificial replacement body parts needed to ease or correct a condition caused by an illness, injury or birth defect, disease or anomaly.

The Certificate of Creditable Coverage section has been deleted in its entirety and replaced with the following:

Blue Cross will provide you or your Dependent a Certificate of Creditable Coverage at the time coverage stops or at the time the COBRA or state continuation coverage stops. If you need a copy of the certificate at a later time, you or your Dependent must request the Certificate of Creditable Coverage within 24 months at the end of coverage, or the end of COBRA or state continuation coverage, whichever occurs first. You or your Dependent may also request a Certificate of Creditable Coverage from us even if your coverage is still force. To request a Certificate of Creditable Coverage, please write or call our Member Services Center at the address or phone number listed in the How to Contact Us section.