

**SOUTH CAROLINA HEALTH INSURANCE POOL (SCHIP)
NETWORK OPTION**

POLICY FORM NO. 12075M (Rev. 4/04)

OUTLINE OF COVERAGE

Read Your Policy Carefully

This Outline of Coverage provides a very brief description of the important features of the policy issued by the South Carolina Health Insurance Pool (SCHIP). This is not the insurance contract and only the actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of you and the South Carolina Health Insurance Pool.

COMPREHENSIVE MAJOR MEDICAL EXPENSE COVERAGE

The policy provides, to persons insured, coverage for major Hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, in-Hospital services and out-of-Hospital care, subject to any Deductibles, copayment provisions or other limitations set forth in the policy.

IMPORTANT

Here is one of the most important things you need to remember about this coverage:

You will receive maximum benefits under this policy if you get approval from the Administrator for inpatient Hospital admissions, Medically Necessary cosmetic reconstructive surgery, Home Health Care, Hospice Care, human organ and/or tissue transplants, Skilled Nursing Facility admissions and certain outpatient services. The amount payable under this policy for these services may decrease if you don't get approval. The *General Information* section of the policy tells you how to get approval from the Administrator for these services.

ELIGIBILITY

This policy provides individual coverage only. Each member of a family can buy his or her own individual coverage if he or she meets the eligibility requirements.

I. Residency Eligibility:

Both the applicant and the Responsible Party (if applicant is under age 18 or legally incapacitated) must have been a "Resident" of South Carolina for at least 30 days. The residency of the Responsible Party fulfills the residency requirement for the an infant under the age of 30 days. The applicant and the Responsible Party must be residents at the time of application and remain residents continuously in order to continue coverage. The Administrator requires documentation of residency at the time of application. While the policy is in force, the Administrator will periodically verify residency.

Applicant Proof of Residency

The applicant must include with the application a copy of one of the following documents or other evidence showing residency for at least 30 days prior to the date of application: rent receipts, mortgage payment receipts, property tax receipts, utility bills or South Carolina driver license. The Administrator may request other documentation.

Proof of Residency for an applicant under Guardianship:

Responsible Party

If an applicant is under age 18 or legally incapacitated, the Responsible Party must include with the application one of the following documents or other evidence showing residency for at least 30 days prior to the date of application: rent receipts, mortgage payment receipts, property tax receipts, utility bills or South Carolina driver license. The Administrator may request other documentation.

Applicant under age 18

For applicants under the age of 18 who are enrolled in school or daycare, the application must include a notarized statement, furnished by the Parent or Legal Guardian and executed by the school or daycare, which reflects the name of the facility in which the child is enrolled, its address and telephone number and the period of time enrolled. If the applicant is not enrolled in school or daycare, the application must include documentation or evidence of residency as requested by the Administrator.

Applicant who is legally incapacitated

For applicants who are legally incapacitated, the application must include any documentation or evidence of residency available and/or documentation requested by the Administrator.

NOTE: To remain eligible for SCHIP coverage, the Policyholder must reside continuously within the State of South Carolina for at least six months of each calendar year. If the Policyholder is under the age of 18 or legally incapacitated, the Responsible Party must also reside continuously within the State of South Carolina for at least the same six months of each calendar year.

II. Medical/Rate Eligibility:

You must provide evidence of any of the following notifications by an insurer on an application for Health Insurance with benefits similar to those offered by SCHIP:

- a. A refusal to issue the insurance for health reasons.
- b. A refusal to issue the insurance except with a reduction or exclusion of coverage for a pre-existing health condition for a period exceeding 12 months. If you: a) voluntarily terminated previous insurance; or b) did not seek any Health Insurance Coverage until after the health condition developed for which benefits would be reduced or excluded, you are not eligible for SCHIP coverage.
- c. A refusal to issue the insurance coverage comparable to that provided by SCHIP except at a rate exceeding 150% of the SCHIP rate.
- d. Received notice that the current rate for comparable Health Insurance is greater than 150% of the SCHIP rate or will be increasing to an amount greater than 150% of the SCHIP rate.

You are not eligible for coverage by SCHIP or for continuance of coverage by SCHIP if you meet any of the following criteria:

- a. You have Health Insurance Coverage similar to that offered by SCHIP from an insurer or any other source unless your premium is greater than 150% of the SCHIP premium.
- b. You are eligible for Health Insurance similar to that offered by SCHIP from an insurer or any other source **unless rule b or c above applies** or unless you are a Federally Defined Eligible Individual or a Qualified TAA Eligible Individual.
- c. You are eligible for healthcare benefits under Medicare.
- d. You previously had coverage by SCHIP that you terminated and less than 12 months have passed since coverage ended (except if you are a Federally Defined Eligible Individual). However, if coverage ended because you were no longer eligible and you now are eligible you can buy insurance from SCHIP. If this is true, the pre-existing conditions limitations must be satisfied based on your new effective date.
- e. You have reached the maximum payout for an individual by SCHIP of \$1,000,000. However, if you have been covered by SCHIP in the past and a lapse of coverage has occurred, the lifetime maximum will be an accumulation and will include all prior benefits paid by SCHIP.
- f. You are an inmate of a public institution (except if you are a Federally Defined Eligible Individual).
- g. You are eligible for public programs that offer comparable Health Insurance Coverage.
- h. You, and/or the Responsible Party if applicable, do not maintain continuous residency within the State of South Carolina for at least six months of each calendar year. Failure to respond to an inquiry about your residency by the Administrator will result in the presumption of non-residency and termination of this policy.
- i. SCHIP finds that your premium, Deductible or Coinsurance amount is paid or reimbursed by a healthcare provider, health agency, health entity, public or private institution or any other person or entity which does not have an insurable interest in the applicant or the Policyholder. This doesn't apply to premiums submitted on your behalf because you are a Qualified TAA Eligible Individual.

III. Federally Defined Eligible Individual or Qualified TAA Eligible Individual Eligibility:

The Residency and Medical/Rate Eligibility requirements are waived for a Federally Defined Eligible Individual or a person eligible under the Trade Adjustment Assistance Act (Qualified TAA Eligible Individual); however, proof of residency will be required within 30 days after acceptance.

EFFECTIVE DATES

Your policy becomes effective as follows:

1. If your Health Insurance Coverage is terminated involuntarily for any reason other than non-payment of premium and you meet the eligibility requirements, the effective date is the date of termination of the prior coverage if you apply within 63 days of termination and pay premiums for the entire coverage period. Pre-existing conditions limitations are waived to the extent to which similar exclusions, if any, have been satisfied under the prior Health Insurance Coverage. The waiver does not apply to a person whose policy has been terminated or rescinded involuntarily because of a material misrepresentation.
2. If you are paying a premium greater than 150% of the SCHIP rate for comparable Health Insurance, the effective date for this coverage will be the date the existing coverage terminates if additional premiums for the existing coverage are not paid. Any Waiting Period or pre-existing condition exclusion is waived to the extent to which similar exclusions, if any, were satisfied under the prior Health Insurance plan. Benefits payable under SCHIP are secondary to benefits payable by Extension of Liability from the previous plan. SCHIP will require a Surcharge to be paid.
3. If a newborn infant meets eligibility requirements and whose parent is covered by SCHIP applies within 63 days of the date of birth, the effective date of the newborn's policy is the date of birth.
4. If none of the above conditions apply, the effective date is the first billing date after the Administrator approves your application.

PRE-EXISTING CONDITIONS LIMITATIONS

SCHIP will not cover any charges or expenses incurred during the first six months after your effective date under this policy for a condition if, during the six-month period immediately before the effective date of coverage:

- The condition would have caused a reasonable person to seek diagnosis, care or treatment; or
- Medical advice, care or treatment was recommended or received for that condition.

The Administrator will waive the pre-existing conditions limitations to the extent that similar exclusions, if any, were satisfied under previous health coverage if you are purchasing this policy because:

1. Your previous health coverage was involuntarily terminated for any reason other than non-payment of premium and you apply within 63 days of termination; or
2. At the time of application for SCHIP, the premium for your current comparable Health Insurance is greater than 150% of the SCHIP rate.

The pre-existing conditions limitations waiver does not apply to a person when the previous policy was terminated or rescinded involuntarily because of material misrepresentation.

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

Federally Defined Eligible Individual – The pre-existing condition limitations will be waived for a Federally Defined Eligible Individual.

Qualified TAA Eligible Individual – The pre-existing condition limitations will be waived for a Qualified TAA Eligible Individual if the person had Creditable Coverage for a total period of three months as of the date when the person seeks to enroll in SCHIP, not counting any period prior to a 63-day break in coverage.

SUMMARY OF BENEFITS

	Network 80/80 Plan	Network 80/60 Plan
Deductible for the Policyholder each Benefit Period	\$500 - the Deductible applies to all covered services.	\$500 - the Deductible applies to all covered services.
Inpatient Per-occurrence Copayment	\$0 per inpatient admission to Non-network Providers.	\$250 per inpatient admission to Non-network Providers.
Outpatient Per-occurrence Copayment	\$100 per Emergency Medical Care facility visit for non-Emergency Medical Condition services	\$100 per Emergency Medical Care facility visit for non-Emergency Medical Condition services

Percentage of Covered Expenses payable per Benefit Period

80% of the Allowable Charge after the Deductible or applicable copayment has been met, for services received from Network and Non-network Providers until the Out-of-pocket Expense has been met.

80% of the Allowable Charge after the Deductible or applicable copayment has been met, for services received from Network Providers until the Out-of-pocket Expense has been met.

60% of the Allowable Charge after the Deductible or applicable copayment has been met, for services received from Non-network Providers until the Out-of-pocket Expense has been met.

After the Out-of-pocket Expense has been met, the policy will pay 100% of the Allowable Charge at Network and Non-network Providers (except for Psychiatric Care and the following when the required prior approvals are not obtained: inpatient Hospital admissions, Medically Necessary cosmetic reconstructive surgery, Home Health Care, Hospice Care, human organ and/or tissue transplants, Skilled Nursing Facility admissions and certain outpatient services).

Outpatient Review

50% of the Allowable Charges are paid for Medically Necessary Home Health Care services, Hospice Care or any of the following outpatient procedures or supplies: chemotherapy or radiation therapy (first treatment only), hysterectomy, septoplasty, sclerotherapy or Durable Medical Equipment (DME) when the cost is \$100 or more when the Outpatient Review approval is not obtained.

If the services aren't Medically Necessary, no benefits are paid even if you call for approval.

Out-of-pocket Expense per Benefit Period –

The Deductible, any Per-occurrence Copayments and Coinsurance amounts for Psychiatric Care do not apply toward your Out-of-pocket Expense.

\$1,500 in Network and out-of-Network

\$2,000 in Network and \$7,000 out-of-Network

Benefit Period

Calendar Year. The first Benefit Period begins on the effective date and ends on December 31. All subsequent Benefit Periods are on a calendar year.

Maximum amount payable in a lifetime for the Policyholder

\$1,000,000 including \$10,000 for combined inpatient and outpatient Psychiatric Care and the Transplant Lifetime Maximums.

Transplant Lifetime Maximums are the maximum amounts of benefits provided in a lifetime for each of the following transplants (preapproval is required). For transplants not listed, the Administrator will determine the Transplant Lifetime Maximum on an individual basis.

Kidney (single/double)	\$60,000
Pancreas and Kidney	\$150,000
Heart	\$120,000
Lung (single/double)	\$150,000
Liver	\$200,000
Heart and (single/double) Lung	\$200,000
Pancreas	\$80,000
Bone Marrow	\$200,000

Daily Hospital room and board

Paid at a semi-private rate.

Other covered Hospital expenses	Miscellaneous inpatient Hospital expenses; outpatient surgery; treatment of accidents; outpatient diagnostic X-ray and lab charges; chemotherapy; inhalation therapy; physical therapy; radiation therapy.
Inpatient Psychiatric Care	50% of the Allowable Charge for covered inpatient expenses after the Deductible up to a maximum of 14 days each Benefit Period.
Emergency Medical Care Facility Per-occurrence Copayment	\$100 for each Emergency Medical Care facility visit for non-Emergency Medical Condition services.
Physicians	Surgery; administration of anesthesia; daily Hospital medical care; outpatient services; treatment of accidents.
Outpatient Psychiatric Care	50% of the Allowable Charge up to \$40 per day, for up to 20 days per Benefit Period.
Home Health Care (Pre-approval required)	Up to 40 days each Benefit Period if prescribed by a Physician.
Physical Therapy	Services of a licensed physical therapist when not inpatient (limited to 20 visits per Benefit Period).
Other Covered Expenses	Prescription drugs, Hospice Care and Durable Medical Equipment (pre-approval required); oxygen and equipment for its use; prosthetic appliances; medical supplies; insulin; ambulance service; blood and blood plasma; home and office visits not part of routine physical exams.
Routine Benefits	<p>OB-GYN (obstetrical-gynecological) examination – For any female Policyholder, limited to two examinations annually.</p> <p>Pap smear screening – Limited to one per female Policyholder per Benefit Period, or more often if recommended by a medical doctor.</p> <p>A pap smear is an examination of cervical cells for the purpose of detecting cancer.</p> <p>Prostate exams, screening and lab work – When performed according to the most recently published American Cancer Society (ACS) guidelines.</p> <p>The most recently published ACS guidelines, dated July 1, 1998, recommend that both Prostate-Specific Antigen (PSA) and Digital Rectal Examination (DRE) should be offered annually to men age 50 and over who have at least a 10-year life expectancy, and to younger men who are at high risk.</p> <p>Men who choose to undergo screening should begin at age 50. However, men in high-risk groups, such as those with a strong familial predisposition (e.g., two or more affected first-degree relatives) or African Americans may begin at age 45. The ACS guidelines are subject to change.</p> <p>Mammography – For any female Policyholder according to the most recently published American Cancer Society (ACS) guidelines.</p> <p>The most recently published ACS guidelines, dated July 1, 1998, recommend an annual mammography for women age 40 and over. The ACS guidelines are subject to change.</p>

For a complete Summary of Benefits please refer to the policy.

SERVICES AND SUPPLIES NOT COVERED

Some services and supplies you may get will not be covered under this policy. Benefits are not provided for the following:

1. Room and board charges in any Hospital or Skilled Nursing Facility when the required approval is not obtained as stated in this policy.

2. When you don't get the required preapproval on certain outpatient procedures, Home Health Care services, Hospice Care and DME, benefits will be reduced as shown in the *Summary of Benefits*.
3. Services, supplies or items that are not Medically Necessary or not specifically listed as a covered benefit in the policy.
4. Services, supplies or treatment you received before you had coverage under this policy or that you receive after you are no longer insured under this policy, except for coverage, if any, provided in the "Termination Provision".
5. Care provided by the Department of Veterans Affairs (VA) for service-related disabilities.
6. Services not charged to you in Hospitals or by agencies.
7. Hospitalization mainly for diagnostic purposes unless such tests require admission to a Hospital.
8. Inpatient admission for the sole purpose of receiving physical therapy.
9. Treatment or tests you receive as an inpatient that could have been done safely as an outpatient.
10. Any amount for Covered Expenses paid or payable through any other Health Insurance or health coverage.
11. All hospital or medical expense benefits paid or payable under workers' compensation (a settled workers' compensation claim is considered paid under workers' compensation), automobile medical payment or liability insurance whether provided on the basis of fault or nonfault.
12. All hospital or medical expense benefits paid or payable under or provided according to any state or federal law or program.
13. Services and supplies related to human organ and/or tissue transplants when preapproval from the Administrator is not obtained and/or services and supplies are not obtained from a provider the Administrator designates.
14. Human organ and/or tissue transplant procedures not specifically listed in this policy.
15. Surgical or medical care related to animal organ transplants, animal tissue transplants, artificial organ transplants or mechanical organ transplants.
16. Investigational or Experimental Services including, but not limited to, the following:
 - Uses of allogenic or syngeneic bone marrow transplants or other forms of stem cell rescue (with or without high doses of chemotherapy or radiation) in cases in which less than four of the six complex antigens match; cases in which mixed leukocyte culture is reactive; and Acquired Immunodeficiency and Human Immunodeficiency Virus infection;
 - Adrenal tissue to brain transplants;
 - Islet cell transplants;
 - Dorsal Rhizotomy in the treatment of spasticity;
 - Procedures that involve the transplantation of fetal tissues into a living recipient.
17. Medical care by a Physician other than the attending Physician during a Hospital admission unless a medical specialist is needed for a condition the attending Physician couldn't treat.
18. Routine physical exams, hearing exams, eye exams (including eye refractions), Hospital nursery charges and the first medical exam of a newborn well baby, well baby care and immunizations.
19. Services and supplies related to cosmetic surgery. This means any plastic or reconstructive surgery done mainly to improve the appearance of any body part, and from which no improvement in physiologic function is reasonably expected, unless performed either to correct functional disorder or as a result of an injury. Cosmetic surgery excluded includes, but isn't limited to:
 - Surgery for sagging or extra skin;
 - Any augmentation or reduction procedures;
 - Rhinoplasty and associated surgery; and
 - Any procedures using an implant that doesn't alter physiologic function or isn't incidental to a surgical procedure.
20. Custodial or intermediate care. This is care meant simply to help people who cannot take care of themselves.
21. Acupuncture.
22. Treatment of obesity or weight reduction, including any surgical procedures specifically designed to treat obesity and any complications arising from such treatment, other than gastric bypass and gastric stapling when Medically Necessary for the treatment of morbid obesity.
23. Hospital charges for dental treatment and any related services and complications.

24. Physician services directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. This includes but is not limited to: apicoectomy (dental root resection), root canal treatment, the excision or extraction of impacted teeth, alveolectomy and treatment of gum disease.
25. Services or supplies related to dysfunctional conditions of the chewing muscles, malpositions or deformities of the jaw bone(s), orthognathic deformities or temporomandibular joint syndrome.
26. Treatment resulting from war or acts of war (whether declared or undeclared); while in the military service or its auxiliary units.
27. An illness you get or injury you receive from participating in a riot or uprising, while committing a crime, felony or misdemeanor or while engaged in an illegal occupation.
28. Educational, occupational, rehabilitative, recreational or speech therapy except as covered in the 14 days annual limit for rehabilitative care described under Covered Inpatient Hospital Expenses.
29. Any type of rehabilitative care for alcohol, drug or other substance abuse.
30. Surgery to correct refractive errors, eyeglasses, contact lenses except after cataract surgery, hearing aids and examinations for their fitting.
31. Prescribed drugs you take home from a doctor's office, Hospital or Skilled Nursing Facility.
32. Prescribed drugs used for or related to birth control, weight control, obesity cosmetic purposes, smoking cessation, hair growth or fertility.
33. More than a 34 consecutive day supply for prescription drugs dispensed by prescription except for 100 unit doses for thyroid products, nitroglycerin, digitalis leaf and alkaloids.
34. Any type of service charge, including the administration or injection of a prescription drug.
35. Devices of any type (even though dispensed by prescription) including, but not limited to, contraceptive devices, therapeutic devices, artificial appliances or similar devices.
36. More than recommended daily dosage of any prescription drug as described in the current Physician's Desk Reference or prescription drug refills beyond one year from the original prescription date.
37. Over the counter supplies including, but not limited to: appliances, bandages, devices, sundries, non-prescription drugs, infant formula and food supplements, even if a Physician prescribes it
38. Private duty nursing services in a Hospital or Skilled Nursing Facility by licensed practical nurses (LPNs), registered nurses (RNs), sitters or companions.
39. Services or care used to detect and correct by manual or mechanical means, structural imbalance, distortion or subluxation in your body for the purpose of removing nerve interference and its effects when this interference is the result of or related to distortion, misalignment or subluxation of or in the spinal column.
40. Any treatment resulting from the Policyholder being intoxicated or under the influence of any narcotic or drug unless prescribed by a Physician.
41. Anesthesiology by the doctor who performs the patient's surgery or who delivers a baby.
42. Any expense or charge for sex change or any treatment related to sexual dysfunction.
43. Any expense or charge for the promotion of fertility including (but not limited to):
 - a. fertility tests;
 - b. reversal of surgical sterilization; and
 - c. any attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer or any similar treatment or method.
44. Care of bunions unless corrected by a surgical procedure; care of corns, calluses, nails of the feet, flat feet, fallen arches, chronic foot strain or symptomatic complaints related to the feet.
45. Any services provided by a relative. A relative means the spouse, parent, grandparent, brother, sister, child or in-law.
46. Services or supplies for which you are not legally obligated to pay.
47. Any intentionally self-inflicted injury or illness, whether sane or insane.
48. Services or supplies not performed or prescribed by a Physician.
49. Travel, luxury or convenience items, even if a Physician recommends it.
50. Advice or consultation given by or through any form of telecommunication such as a telephone consultation or a virtual office visit via the Internet.

51. Charges for completion of any insurance form or as the result of a missed appointment.
52. Any service or treatment for complications resulting from any non-covered procedures.

RENEWABILITY

SCHIP may non-renew this policy for the reasons stated below.

If the Administrator finds that you do not meet any of the eligibility requirements described in this policy, it will decline to renew your policy the next time your premium is due. SCHIP may decline to renew your policy if Act 127 of 1989 is amended or repealed and SCHIP is instructed not to renew existing policies. SCHIP may decline to renew your policy if a new policy form replaces this policy form. If SCHIP replaces the policy form, SCHIP may offer to replace everyone's policy with the new policy form.

SCHIP will not decline to renew your policy simply because of a change in your physical or mental health except as specified in the *Eligibility* section.

You will receive 31 days written notice if SCHIP doesn't renew your policy.

RENEWAL AND TERMINATION

Your policy will be renewed for one month each time you pay the required premium by the due date or within the 31-day grace period until the earliest of the following dates:

1. The next premium due date following the date you are no longer eligible according to the rules under the *Eligibility* section;
2. The date you request the policy to end;
3. The date South Carolina statutes require cancellation of the policy;
4. The date of any fraudulent act as determined by the Board. In the case of material misrepresentation in application, the policy will be rescinded as of the effective date of coverage;
5. The date that the Board determines that your premium, Deductible or Coinsurance amount is being paid or reimbursed by a healthcare provider, health agency, health entity, public or private institution, or any other person or entity which does not have an insurable interest in the applicant or Policyholder.

PREMIUMS

The included premium rate sheet shows the current premium charged for each attained age group for this policy. SCHIP has the right to change this table of premiums on a class basis. If this table of premiums changes, the Administrator will tell you at least 31 days in advance of the date that the change affects you.

Note that your premium also changes as you enter an older attained age group.

You pay premiums each month. If premiums change, you pay the new rates the next time your premium is due.

EXTENSION OF BENEFITS AFTER TERMINATION OF COVERAGE

Extension of Benefits does not apply if SCHIP does not renew your policy because you fail to meet the eligibility requirements, or because South Carolina statutes require cancellation of your policy or because the Board determines that you defrauded SCHIP. If SCHIP does not renew the policy for any other reason, and you are in the Hospital or Continuously Disabled when the coverage under the policy ends, benefits will be paid while you remain Continuously Disabled for the same or a related cause. Payments will only be made for services related to the disabling condition and will continue until the earlier of:

1. The date of recovery from Continuous Disability.
2. You receive benefits for Covered Expenses for up to 365 days from the date the coverage is terminated.
3. You use all benefits available under the policy.

SOUTH CAROLINA HEALTH INSURANCE POOL

POLICY DATA PAGE

This policy is administered by: Blue Cross[®] and Blue Shield[®] of South Carolina

Insured: [Jane H Doe] Effective Date: [July 1, 2003]

Policy Number: [888-88-8888] Premium amount: [\$000.00]

If you have any questions about rates or eligibility, please call or write:

Toll Free in South Carolina
Local Columbia Area

1-800-868-2500, ext. 46401
803-264-6401

SCHIP
Post Office Box 61173
Columbia, SC 29260

If you have any questions about your health and drug coverage or benefits (including appeals), please call or write:

Toll Free in South Carolina:
Local Columbia Area:

1-800-868-2500, ext. 43475
803-264-3475

SCHIP
Post Office Box 61173
Columbia, SC 29260

To obtain approval for inpatient non-maternity hospital admissions, Medically Necessary cosmetic reconstructive surgery, home health care, human organ transplant, Skilled Nursing Facility admissions and certain outpatient services, please call:

Toll Free in South Carolina
Toll Free from outside of South Carolina
Local Columbia Area:

1-800-327-3238
1-800-334-7287
803-736-5990

Medical Expense Benefit Description

Deductible Amount:

Deductible amount each Benefit Period – **all** Covered Expenses are subject to the Deductible unless otherwise stated \$500

The Deductible does not count toward your Out-of-pocket Expense.

Per-occurrence Copayments:

Admission to a Network Facility	\$0
Admission to a non-Network Facility	\$250
Emergency Medical Care facility visit for non-Emergency Medical Condition services	\$100

The Per-occurrence Copayment for each non-accident admission to a non-Network Hospital and the Per-occurrence Copayment for each visit to an Emergency Medical Care facility for non-Emergency Medical Condition services do not count toward your Out-of-pocket Expense.

Percent Payable:

Network Providers (including Contracting Providers):
80% of the Allowable Charge

Non-network Providers (including non-Contracting Providers):
60% of the Allowable Charge

Prescription Drugs (dispensed only by prescription)

80% of the Allowable Charge when purchased at a Participating Network Pharmacy

60% of the Allowable Charge when purchased at a non-Participating Network Pharmacy

Additional Covered Expenses:

Psychiatric Benefits – Preapproval is required. If preapproval is not obtained, no benefits are payable. 50% of the Allowable Charge. Limited to 14 days for covered inpatient expenses each Benefit Period and 20 days, up to \$40 per day, for covered outpatient expenses each Benefit Period. The Coinsurance amount for Psychiatric Care does not count toward your Out-of-pocket Expense.

Outpatient physical therapy – Limited to 20 visits each Benefit Period.

Home Health Care – Limited to 40 days each Benefit Period.

Outpatient Review:

You must get Outpatient Review approval before you receive Home Health Care services, Hospice Care or any of the following outpatient procedures or supplies: chemotherapy or radiation therapy (first treatment only), hysterectomy, septoplasty, sclerotherapy or Durable Medical Equipment (DME) when the cost is \$100 or more.

If you don't call for approval, 50% of the Allowable Charges are paid for services that are Medically Necessary. If the services aren't Medically Necessary, no benefits are paid even if you call for approval.

Out-of-pocket Expense maximum each Benefit Period:

Network Provider Out-of-pocket Expense maximum	\$2,000
Non-Network Out-of-pocket Expense maximum	\$7,000

After the Out-of-pocket Expense has been met, this policy will pay 100% of the Allowable Charge at Network and non-Network Providers for the rest of the Benefit Period (except for Psychiatric Care and the following when the required prior approvals are not obtained: inpatient Hospital admissions, Medically Necessary cosmetic reconstructive surgery, Home Health Care, Hospice Care, human organ and/or tissue transplants, Skilled Nursing Facility admissions and certain outpatient services).

Lifetime Maximum Benefits \$1,000,000

The Lifetime Maximum Benefit of \$1,000,000 includes the following more restrictive Lifetime Maximum Benefits:

Psychiatric Care (inpatient, outpatient and office visits combined)	\$10,000
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Transplant Lifetime Maximum

Each of the following transplant procedures are subject to the Transplant Lifetime Maximums that are listed below. For transplants not listed below, the Administrator will determine the Transplant Lifetime Maximum on an individual basis.

Kidney (single/double)	\$60,000
Pancreas and Kidney	\$150,000
Heart	\$120,000
Lung (single/double)	\$150,000
Liver	\$200,000
Heart and (single/double) Lung	\$200,000
Pancreas	\$80,000
Bone Marrow	\$200,000

However, if you have been covered by the SCHIP in the past and a lapse of coverage has occurred, the lifetime maximum will be an accumulation and will include all prior benefits paid by the SCHIP.

Expecting for Tomorrow

This program applies to all female Policyholders.

The Administrator encourages expectant mothers to seek the proper prenatal care to help give their babies a healthier start in life. To help eligible pregnant Policyholders with this, we offer the *Expecting for Tomorrow* program. This program gives you access to experienced maternity nurses, free educational materials and helpful advice throughout your pregnancy.

The staff of *Expecting for Tomorrow* works with your Physician or OB/GYN to help you identify and prevent any potential risks or complications. That way, you can improve your odds of having a healthier baby.

To enroll in *Expecting for Tomorrow*, call the Administrator’s Medical Services personnel at the number shown on your ID card. A case manager will be happy to tell you more about the program.

Your Fastest Place for Answers – www.SouthCarolinaBlues.com

If you have access to the Internet you can find quick and easy answers to your health coverage questions any time of day or night. When you go to www.SouthCarolinaBlues.com, you'll find useful tools that can help you better understand your coverage.

Here are some of the things you can do on the Administrator's Web site:

- Stay informed with all the latest press releases and legislative issues
- Links to other health-related Web sites
- Use My Insurance Managersm
- Locate a network Physician, Hospital or Pharmacy

On My Insurance Manager

You can:

- Check your eligibility
- See how much you've paid toward your Deductible or Out-of-pocket Expense
- Check on Authorizations
- Find out if the Administrator has processed your claims
- Order a new ID card
- Ask a representative a question through secure e-mail
- View your Explanation of Benefits (EOB)

You can do all this and more when you use the Administrator's convenient and secure My Insurance Manager feature.

The BlueCard® Program.

As the Administrator and a Blue Cross® and Blue Shield® Licensee, BlueCross participates in a national program called the BlueCard Program. *This program benefits you when you receive Covered Services while traveling outside the Company's service area.* The "BlueCard" is your BlueCross identification card. Your card tells participating BlueCard hospitals and/or Physicians which independent Blue Cross and Blue Shield Licensee is yours. If you need care while away from home, follow these easy steps:

- Always carry your current BlueCross ID card for easy reference and access to service.
- To find names and addresses of nearby doctors and hospitals, visit the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call BlueCard Access at 800-810-BLUE.
- When you arrive at the participating doctor's office or Hospital, simply present your BlueCross ID card.

After you receive care, you should not have to complete any claim forms. Nor should you have to pay for medical

services other than your usual out-of-pocket expenses (non-Covered Services, Deductible, Copayment, and Coinsurance). You should see your primary care Physician for any follow-up care.

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. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare 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 Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside our service area, you will receive it from one of two kinds of Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("non-participating Providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claims Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits, except when paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by us to provide the specific service or services.

1. BlueCard® Program

Under the BlueCard® Program, when you receive covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

When you receive Covered Services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed 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 healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare 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 healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims as noted above. However, such adjustment will not affect the price we have used for your claim because they will not be applied after a claim had already paid.

2. Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue’s service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to us through average pricing or fee schedule adjustments.

3. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

4. Nonparticipating Providers Outside Our Service Area

Member Liability Calculation

When Covered Services are provided outside of our service area by non-participating Providers, information regarding the amount you pay for such services is contained in the Covered Services section of this Booklet. Federal or state law, as applicable, will govern payments for out-of-Network emergency services.

Blue Cross Blue Shield Global® Core If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter “BlueCard service area”), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is not served by a Host Blue. As such, when you receive care from providers outside

the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts, deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the Blue Cross Blue Shield Global Core Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Healthcare Services. **You must contact Blue Cross and Blue Shield of South Carolina to obtain precertification for non-emergency inpatient services.**

- **Outpatient Services**

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

When you pay for Covered Healthcare Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Blue Cross and Blue Shield of South Carolina, the Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, and seven days a week.

SOUTH CAROLINA HEALTH INSURANCE POOL (SCHIP) NETWORK PLAN

South Carolina Act 127 of 1989 created a Health Insurance Pool (SCHIP) to make Health Insurance Coverage available to certain residents of South Carolina. The Eligibility section of this policy lists the eligibility requirements for purchasing insurance from SCHIP. SCHIP will issue policies unless the State amends or repeals Act 127 of 1989. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) changes made in this policy are based on federal law.

YOUR RIGHT TO EXAMINE THIS POLICY

This policy is a Health Insurance policy. When you get it, you have **30 days** to examine it, your application and any amendments, riders or endorsements to the policy.

Read the policy carefully. If you're not happy with it, you may return it within **30 days** to the Administrator with a note that says you don't want it. If you do that, the Administrator will return any premiums you have paid.

NON-RENEWABLE FOR STATED REASONS ONLY

SCHIP may non-renew this policy for the reasons stated below and under the Eligibility Section of this policy.

If the Administrator finds that you do not meet any of the eligibility requirements described in this policy, it will decline to renew your policy the next time your premium is due. SCHIP may decline to renew your policy if Act 127 of 1989 is amended or repealed and SCHIP is instructed not to renew existing policies. SCHIP may decline to renew your policy if a new policy form replaces this policy form. If SCHIP replaces the policy form, SCHIP may offer to replace everyone's policy with the new policy form.

SCHIP will not decline to renew your policy simply because of a change in your physical or mental health except as specified in the Eligibility section.

You will receive 31 days written notice if SCHIP doesn't renew your policy.

SOUTH CAROLINA HEALTH INSURANCE POOL

IMPORTANT

The Administrator has an approval process in place. You will receive maximum benefits available for Covered Expenses under this policy if you get approval from the Administrator for inpatient Hospital admissions, Medically Necessary cosmetic reconstructive surgery, Home Health Care, Hospice Care, human organ and/or tissue transplants, Skilled Nursing Facility admissions and certain outpatient services. The amount payable under this policy for these services may decrease if you don't get approval. The *General Information* section of this policy tells you how to get approval from the Administrator for these services.

An approval only means that a service is Medically Necessary for treatment of the patient's condition. It is not a guarantee or verification of benefits. Payment is subject to eligibility, Pre-existing Condition Limitations and all other policy limitations and exclusions.

TABLE OF CONTENTS

Your Right to Examine This Policy	1
Non-Renewable for Stated Reasons Only.....	1
Policy: When It’s Valid	4
About Premiums	4
Eligibility and Effective Dates	4-6
Eligibility	4
Effective Dates	5
Definitions and Related Coverage Requirements.....	6-11
Administrator.....	6
Allowable Charge.....	6
Benefit Period.....	6
Board.....	6
Carryover Deductible Provision.....	6
Coinsurance	6
Continuously Disabled	6
Contracting Provider	6
Contracting Provider Agreement	6
Covered Expenses	6
Creditable Coverage	7
Deductible.....	7
Durable Medical Equipment	7
Emergency Medical Care.....	7
Emergency Medical Condition	7
Extension of Benefits after Termination of Coverage.....	7
Federally Defined Eligible Individual.....	8
Genetic Information.....	8
Group Health Plan	8
Health Insurance or Health Insurance Coverage	8
Home Health Agency	8
Home Health Care	8
Hospice Care.....	9
Hospital.....	9
Investigational or Experimental	9
Medically Necessary	10
Medicare	10
Network Plan	10
Network Providers.....	10
Non-network Provider.....	10
Obstetrical Services.....	10
Out-of-pocket Expense.....	10
Percent Payable.....	10
Per-occurrence Copayment	10
Pharmacy Benefit Manager (PBM)	10
Physician.....	10
Policyholder.....	11
Psychiatric Care.....	11

Qualified TAA Eligible Individual	11
Resident	11
Responsible Party	11
Skilled Nursing Facility (SNF)	11
Surcharge	11
Surgical Assistant	11
Transplant Benefit Period	11
Transplant Lifetime Maximum	11
Waiting Period.....	11
General Information	
Approval for Coverage of Treatment	11-12
Preadmission Review	12
Emergency Admission Review	12
Continued Stay Review	12
Medically Necessary Cosmetic Reconstructive Surgery.....	12
Outpatient Review	12
Emergency Medical Care by a Non-network Provider.....	12
How Benefits Are Paid.....	13
Covered Expenses.....	13-17
Covered Inpatient Hospital Expenses	13
Covered Outpatient Hospital Expenses	13
Covered Physician Expenses.....	14
Other Covered Expenses	14
Pre-existing Conditions Limitations	17
Services and Supplies Not Covered	17-19
Renewal and Termination Agreement	19-20
General Policy Provisions	20-21
Time Limit to File a Claim.....	21
How to Get Help from the South Carolina Health Insurance Pool	21
Appeal Procedures	21-22
Continuation of Care	22-23

POLICY: WHEN IT'S VALID

It takes three things to put this policy into effect. The first is your application along with all required proofs of eligibility. The second is your first payment. The third is acceptance of your application by the Administrator. The policy goes into effect according to the rules on pages 5-6.

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

ABOUT PREMIUMS

The included premium rate sheet shows the current premium charged for each attained age group for this policy. The Pool has the right to change this table of premiums on a class basis. If this table of premiums changes, the Administrator will tell you at least 31 days in advance of the date that the change affects you.

Note that your premium also changes as you enter an older attained age group.

You pay premiums each month. If premiums change, you pay the new rates the next time your premium is due.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility

This policy provides individual coverage only. Each member of a family can buy his or her individual coverage if he or she meets the eligibility requirements.

I. Residency Eligibility:

Both the applicant and the Responsible Party (if applicant is under age 18 or legally incapacitated) must have been a "Resident" of South Carolina for at least 30 days. The residency of the Responsible Party fulfills the residency requirement for an infant under the age of 30 days. The applicant and the Responsible Party must be residents at the time of application and remain residents continuously in order to continue coverage. The Administrator requires documentation of residency at the time of application. While the policy is in force, the Administrator will periodically verify residency. .

Applicant Proof of Residency

The applicant must include with the application a copy of one of the following documents or other evidence showing residency for at least 30 days prior to the date of application: rent receipts, mortgage payment receipts, property tax receipts, utility bills or South Carolina driver license. The Administrator may request other documentation.

Proof of Residency for an applicant under Guardianship

Responsible Party

If an applicant is under age 18 or legally incapacitated, the Responsible Party must include with the application one of the following documents or other evidence showing residency for at least 30 days prior to the date of application: rent receipts, mortgage payment receipts, property tax receipts, utility bills or South Carolina driver license. The Administrator may request other documentation.

Applicant under age 18

For applicants under the age of 18 who are enrolled in school or daycare, the application must include a notarized statement, furnished by the Parent or Legal Guardian and executed by the school or daycare, which reflects the name of the facility in which the child is enrolled, its address and telephone number and the period of time enrolled. If the applicant is not enrolled in school or daycare, the application must include documentation or evidence of residency as requested by the Administrator.

Applicant who is legally incapacitated

For applicants who are legally incapacitated, the application must include any documentation or evidence of residency available and/or documentation requested by the Administrator.

NOTE: To remain eligible for SCHIP coverage, the Policyholder must reside continuously within the State of South Carolina for at least six months of each calendar year. If the Policyholder is under the age of 18 or legally incapacitated, the Responsible Party must also reside continuously within the State of South Carolina for at least the same six months of each calendar year.

II. Medical/Rate Eligibility:

You must provide evidence of any of the following notifications by an insurer on an application for Health Insurance with benefits similar to those offered by SCHIP:

- a. A refusal to issue the insurance for health reasons.
- b. A refusal to issue the insurance except with a reduction or exclusion of coverage for a pre-existing health condition for a period exceeding 12 months. If you: a) voluntarily terminated previous insurance; or b) did not seek any Health Insurance Coverage until after the health condition developed for which benefits would be reduced or excluded, you are not eligible for SCHIP coverage.
- c. A refusal to issue the insurance coverage comparable to that provided by SCHIP except at a rate exceeding 150% of the SCHIP rate.
- d. Received notice that the current rate for comparable Health Insurance is greater than 150% of the SCHIP rate or will be increasing to an amount greater than 150% of the SCHIP rate.

You are not eligible for coverage by SCHIP or for continuance of coverage by SCHIP if you meet any of the following criteria:

- a. You have Health Insurance Coverage similar to that offered by SCHIP from an insurer or any other source unless your premium is greater than 150% of the SCHIP premium.
- b. You are eligible for Health Insurance similar to that offered by SCHIP from an insurer or any other source **unless rule b or c above applies** or unless you are a Federally Defined Eligible Individual or a Qualified TAA Eligible Individual.
- c. You are eligible for health care benefits under Medicare.
- d. You previously had coverage by SCHIP that you terminated and less than 12 months have passed since coverage ended (except if you are a Federally Defined Eligible Individual). However, if coverage ended because you were no longer eligible and you now are eligible, you can buy insurance from SCHIP. If this is true, the pre-existing conditions limitations must be satisfied based on your new effective date.
- e. You have reached the maximum payout for an individual by SCHIP of \$1,000,000. However, if you have been covered by SCHIP in the past and a lapse of coverage has occurred, the lifetime maximum will be an accumulation and will include all prior benefits paid by SCHIP.
- f. You are an inmate of a public institution (except if you are a Federally Defined Eligible Individual).
- g. You are eligible for public programs that offer comparable Health Insurance Coverage.
- h. You, and/or the Responsible Party if applicable, do not maintain continuous residency within the State of South Carolina for at least six months of each calendar year. Failure to respond to an inquiry about your residency by the Administrator will result in the presumption of non-residency and termination of this policy.
- i. SCHIP finds that your premium, Deductible or Coinsurance amount is paid or reimbursed by a health care provider, health agency, health entity, public or private institution or any other person or entity which does not have an insurable interest in the applicant or the Policyholder. This doesn't apply to premiums submitted on your behalf because you are a Qualified TAA Eligible Individual.

III. Federally Defined Eligible Individual or Qualified TAA Eligible Individual Eligibility:

The Residency and Medical/Rate Eligibility requirements are waived for a Federally Defined Eligible Individual or a person eligible under the Trade Adjustment Assistance Act (Qualified TAA Eligible Individual); however, proof of residency will be required within 30 days after acceptance.

Effective Dates

Your policy becomes effective as follows:

1. If your previous Health Insurance Coverage is terminated involuntarily for any reason other than non-payment of premium and you meet the eligibility requirements, the effective date is the date of termination of the prior coverage if you apply within 63 days of termination and pay premiums for the entire coverage period. Pre-existing conditions limitations are waived to the extent to which similar exclusions, if any, have been satisfied under the prior Health Insurance Coverage. The waiver does not apply to a person whose policy has been terminated or rescinded involuntarily because of a material misrepresentation.

2. If you are paying a premium greater than 150% of the SCHIP rate for comparable Health Insurance, the effective date for this coverage will be the date the existing coverage terminates if additional premiums for the existing coverage are not paid. Any Waiting Period or pre-existing condition exclusion is waived to the extent to which similar exclusions, if any, were satisfied under the prior Health Insurance plan. Benefits payable under SCHIP are secondary to benefits payable by Extension of Liability from the previous plan. SCHIP will require a Surcharge to be paid.
3. If a newborn infant meets eligibility requirements and whose parent is covered by SCHIP applies within 63 days of the date of birth, the effective date of the newborn's policy is the date of birth.
4. If none of the above conditions apply, the effective date is the first billing date after the Administrator approves your application.

DEFINITIONS AND RELATED COVERAGE REQUIREMENTS

Words and terms you need to know to help you understand your Health Insurance:

Administrator: A company appointed by the SCHIP Board to administer this policy.

Allowable Charge: For Network Providers, this means the allowance mutually agreed upon by the Network Provider and the Administrator and set forth in the written Network Provider agreement. In the event the Allowable Charge does not apply for a specific service or supply, the allowance will be the actual charge as submitted or the Maximum Payment, whichever is less. The Allowable Charge for all other providers means the actual charge as submitted or "Maximum Payment," whichever is less.

Maximum Payment is the total amount eligible for payment by the Administrator for the services, supplies or equipment you receive from a provider, as determined by the Administrator. The Maximum Payments will be the least of 1, 2, 3, 4 or 5:

1. The charges made during the last year by all Physicians or suppliers who perform the same service;
2. The Maximum Payment for the last year increased by an index based on national or local economic factors or indices;
3. The lowest charge for similar services and supplies;
4. Allowances agreed on by Contracting Providers and the Administrator; or
5. A set of allowances the Administrator establishes.

Review of the Maximum Payment will occur following each calendar year. If there are no actual or similar charges as referred to above, the Administrator may, through its medical staff and/or consultants, determine the Maximum Payment based on comparable or similar services or procedures. The Allowable Charge may be subject to a Deductible and/or Coinsurance as shown in your Policy Data Page.

Benefit Period: A calendar year. The first Benefit Period begins on the effective date of your coverage and ends on December 31. All subsequent Benefit Periods are on a calendar year.

Board: The Board of Directors of the South Carolina Health Insurance Pool (SCHIP).

Carryover Deductible Provision: Eligible expenses used to satisfy the Deductible during the last 90 days of a year may also be applied to satisfy the Deductible for the next calendar year.

Coinsurance: The percentage of Allowable Charges you pay as your share of Covered Expenses. This percentage is applied to the negotiated rate or lesser charge when the Administrator has negotiated rates with your Provider for Covered Expenses provided by this policy.

Continuously Disabled: A Policyholder who is receiving ongoing medical care by a Physician and is not able to do the material and substantial duties or activities of a person of the same age and sex who is in good health.

Contracting Provider: Any provider with which the Administrator has a Contracting Provider Agreement including any licensed Hospital, Physician, supplier, pharmacy, Skilled Nursing Facility or Home Health Agency.

Contracting Provider Agreement: A written agreement between the Administrator and a healthcare provider.

Covered Expenses: Medical services and supplies that are Medically Necessary in the diagnosis or treatment of an illness or injury for which a Policyholder is entitled to benefits according to the terms and conditions of this policy.

Creditable Coverage: With respect to an individual, coverage of the individual under any of the following:

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 Benefit 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).

There must be no more than a 63-day break between two different health coverages. Any period during which the Policyholder is in a Waiting Period may not be taken into account in determining the 63-day period.

Deductible: The amount of Allowable Charges you are responsible for paying each Benefit Period before benefits are payable on a claim for Covered Expenses. The Deductible applies to all Covered Expenses unless otherwise noted. Any expenses used to satisfy the Deductible do not apply towards satisfying the Out-of-pocket Expense limit.

Durable Medical Equipment: Durable Medical Equipment means any equipment that:

1. Can withstand repeated use; and
2. Is primarily and customarily used to serve a medical purpose rather than for transportation, comfort or convenience; and
3. Is generally not useful to a person in the absence of illness or injury; and
4. Is appropriate for use in the home and reduces or eliminates the time required for Hospital or Skilled Nursing Facility confinement; and
5. Is a device or other appliance.

A Physician must order such devices or equipment and the Administrator must approve them as Medically Necessary to meet a specific medical need. Your Physician must certify in writing that such equipment is Medically Necessary. The Administrator may, from time to time, require proof that the equipment is still Medically Necessary. After considering cost and availability, the Administrator will decide whether to buy or rent (up to purchase price) the equipment. Such devices must be medical in nature that is, wheelchairs, splints, respirators, etc. To qualify as Durable Medical Equipment, the equipment's use must be limited to the patient for whom it is ordered, that is, others could not use the device or equipment.

Devices such as air conditioners, (de) humidifiers, physical fitness equipment, whirlpool baths, spas, vacuum cleaners, heating pads or air filters would not qualify as Durable Medical Equipment as they do not have exclusive medical uses even when prescribed by a Physician. Benefits are not provided for:

- Deluxe equipment (such as motor-driven wheelchairs) when standard equipment is adequate;
- Equipment when you are in a facility that provides this equipment;
- Structural changes to your home or vehicle;
- Repair costs that exceed the rental or purchase of new equipment for the period of time you need it; and
- Shipping costs of Durable Medical Equipment.

Emergency Medical Care: Those healthcare services provided in a Hospital emergency facility to evaluate and treat an Emergency Medical Condition.

Emergency Medical Condition: A severe injury or illness (including pain). The injury or illness must be so severe that a reasonable person with average knowledge of health and medicine could reasonably expect that if he or she doesn't get medical care right away, one of these might occur:

1. Serious risk to one's health. If a woman is pregnant, this includes her health or her unborn child's health;
2. Serious damage to body functions; or
3. Serious damage to any organs or body parts.

Extension of Benefits after Termination of Coverage: Extension of Benefits does not apply if SCHIP does not renew this policy because you fail to meet the eligibility requirements, or because South Carolina statutes require cancellation of your policy or because the Board determines that you defrauded SCHIP. If SCHIP does not renew this policy for any other reason, and you are in the Hospital or Continuously Disabled when the coverage under this policy ends, benefits

will be paid while you remain Continuously Disabled for the same or a related cause. Payments will only be made for services related to the disabling condition and will continue until the earlier of:

1. The date the hospitalization ends or the date of recovery from Continuous Disability.
2. You receive benefits for Covered Expenses for up to 365 days from the date this coverage is terminated.
3. You use all benefits available under this policy.

Federally Defined Eligible Individual: An individual who meets all of the following:

1. You must have had 18 months of continuous Creditable Coverage, at least the last day of which was under a Group Health Plan; and
2. You also must have used up any COBRA or state continuation coverage for which you were eligible; and
3. You must not be eligible for Medicare, Medicaid or a Group Health Plan; and
4. You must not have Health Insurance; and
5. You must apply for Health Insurance for which you are federally eligible within 63 days of losing your prior coverage.

Genetic Information: Information about genes, gene products or genetic characteristics that are passed down from parents to children. 'Gene product' is a scientific term that means messenger RNA and translated protein. Genetic Information doesn't include:

- Routine physical measurements;
- Chemical, blood and urine analysis, unless purposely done to diagnose a genetic characteristic;
- Tests for drug abuse; and
- Tests for the presence of the human immunodeficiency virus (HIV).

Group Health Plan: Health Insurance coverage purchased by an employer from an insurance company for eligible employees and their dependents and/or retirees of the same employer and their dependents.

Health Insurance or Health Insurance Coverage: Benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under a hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by an insurer, except:

1. Coverage only for accident or disability income insurance, or any combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics;
8. Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
9. If offered separately:
 - a. Limited scope dental or vision benefits;
 - b. Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof;
 - c. Such other similar, limited benefits as are specified in regulation;
10. If offered as independent, noncoordinated benefits:
 - a. Coverage only for a specified disease or illness; and
 - b. Hospital indemnity or other fixed indemnity insurance;
11. If offered as a separate insurance policy, coverage supplemental to the coverage provided under Military, TRICARE or CHAMPUS.

Prior coverage under any of the above items (1) through (11) will not be counted as Creditable Coverage.

Home Health Agency: Any organization licensed by the state of South Carolina to render home health services to Policyholders.

Home Health Care: Includes services you get in the home that are normally provided in lieu of otherwise needed inpatient care at a Hospital or Skilled Nursing Facility. You must receive Home Health Care from a Home Health Agency that is licensed by the state in which it operates. The Administrator must also approve Home Health Care benefits in advance.

Hospice Care: A program of care for terminally ill people who aren't expected to live more than six months. It must be provided in lieu of inpatient care at a Hospital or Skilled Nursing Facility to a patient who would otherwise need inpatient care. The Administrator must also approve Hospice Care benefits in advance.

Hospital: A short-term, acute care facility that:

1. Is licensed and operated according to the law; and
2. Is primarily and continuously engaged in providing or operating medical, diagnostic, therapeutic and major surgical facilities for the medical care and treatment of injured or sick people on an inpatient basis either on its premises or in facilities available to the Hospital on a prearranged basis and 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 rehabilitative care; or
3. For the treatment of substance or alcohol abuse; or
4. For the treatment of mental or nervous conditions.

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

Investigational or Experimental: The use of services or supplies that the Administrator doesn't recognize as standard medical care for the treatment of conditions, diseases, illnesses or injuries. These include but are not limited to, treatments, procedures, facilities, equipment, drugs or devices. Here are the criteria the Administrator uses to base its 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. A drug that has not been approved by the FDA for the treatment of a specific type of cancer for which a Physician has prescribed the drug, however, may not be excluded if any of these criteria are met:
 - a. The drug is recognized for treatment of a specific type of cancer in at least one standard reference compendia.
 - b. The drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies. These results must have been published in peer-reviewed professional medical journals.

Standard reference compendia means any of the following:

- a. The United States Pharmacopeia dispensing information; or
 - b. The American Hospital Formulary Service drug information.
2. There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to let the Administrator 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 Administrator solely makes these determinations after independent review of scientific data. The Administrator may also consider opinions of professionals in a particular field and/or opinions and assessments of nationally recognized review organizations but they are not determinative or conclusive.

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

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

Medically Necessary: Benefits are payable for services or supplies that are Medically Necessary. This means that a service or supply you receive must be used to identify or treat the injury or illness that a Physician has diagnosed or reasonably suspects. The service or supply must:

- Be consistent with proper diagnosis or treatment;
- Conform to standards of good medical practice;
- Be performed in the least costly setting allowed by the patient's condition; and
- Not be performed simply for the convenience of the patient or the doctor.

The simple fact that a doctor performs, prescribes or suggests a service, supply or equipment does not mean it is Medically Necessary.

Medicare: The program of healthcare for the aged, disabled and individuals with end stage renal disease established by Title XVIII of the Social Security Act of 1965, as amended.

Network Plan: Health Insurance Coverage under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the insurer.

Network Providers: Hospitals, Skilled Nursing Facilities, Home Health Agencies, hospices, doctors and other providers of medical services and suppliers who have a written agreement with the Administrator to do the following things:

1. File all claims for covered services or supplies for you; and
2. Ask you to pay only the Deductible and Coinsurance for Covered Expenses (Deductibles and Coinsurance are part of the allowance for Covered Expenses that this coverage does not pay.); and
3. Accept the Allowable Charge as payment in full for Covered Expenses (You are responsible for any Deductibles and Coinsurance).

There are two ways to find out if your provider is a Network Provider - check the Network Provider Directory or ask your provider before you receive services or supplies. Network Providers are subject to change.

Non-network Providers: Hospitals, Skilled Nursing Facilities, Home Health Agencies, hospices, doctors and other providers of medical services and suppliers who do not have a written agreement with the Administrator. This means you may pay more money out of your own pocket. The Non-network Provider benefit percentage is shown in you Policy Data Page.

The Administrator encourages you to use Network Providers whenever you can for a number of reasons:

1. Non-network Providers may require you to pay the full amount of their charges at the time you receive services; and
2. Non-network Providers may require you to file your own claims; and
3. Non-network Providers may require you to get all necessary Approvals. Information regarding how and when to get an Approval is in the *General Information* section of this policy; and
4. Non-network Providers can also charge you more than the Allowable Charge.

The Administrator makes every effort to contract with Physicians who practice at Network Hospitals. Some Physicians, however, choose not to be Network Providers even though they may practice at Network Hospitals. It's important to understand that while you can still use these Physicians, the benefit percentage paid may be lower.

Obstetrical Services: Any service or treatment related to or arising from the state of pregnancy.

Out-of-pocket Expense: Coinsurance amounts for Covered Expenses that you must pay. It does not include any Deductible amounts or any Coinsurance for psychiatric benefits; any Per-occurrence Copayment amounts; charges in excess of the Allowable Charge; amounts exceeding any maximum payments for benefits; or any expense not allowed according to any provisions of this policy.

Percent Payable: The percentage of Allowable Charges the Administrator pays for Covered Expenses. This percentage is applied to the negotiated rate or lesser charge when the Administrator has negotiated rates with your Provider for Covered Expenses provided by this policy.

Per-occurrence Copayment: A fee you pay each time you receive a certain service or supply. Copayments don't go toward reaching your Deductible or Out-of-pocket Expense maximum. They will continue to apply even after you meet your Deductible or Out-of-pocket Expense maximum.

Pharmacy Benefit Manager (PBM): A company that has a written contract with the Administrator to manage the Prescription Drug benefits according to this policy.

Physician: Any practitioner of the healing arts, other than a Policyholder or a person related to a Policyholder, legally licensed to perform any service covered by this insurance policy.

Policyholder: Any person who meets all of the eligibility requirements and is covered under this policy.

Psychiatric Care: Treatment of mental or nervous conditions and detoxification treatment for substance or alcohol abuse. Psychiatric Care does not include rehabilitative care needed because of abuse of drugs, alcohol or other substances.

Qualified TAA Eligible Individual: A person who is eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986, which includes the following persons as defined in Section 35:

1. Eligible TAA (Trade Adjustment Assistance) recipient;
2. Eligible ATAA (Alternative Trade Adjustment Assistance) recipient; or
3. Eligible PBGC (Pension Benefit Guaranty Corporation) pension recipient.

Resident: Any person who has resided continuously within the State of South Carolina for at least 30 days immediately before he or she applies for this Health Insurance. This requirement is waived for a Federally Defined Eligible Individual or a Qualified TAA Eligible Individual. However, proof of residency will be required within 30 days after acceptance.

Responsible Party: Contractor for the applicant if applicant is under age 18 or legally incapacitated, limited to one of the following: natural parent, adoptive parents, grandparent or legal guardian.

Skilled Nursing Facility (SNF): A licensed institution, other than a Hospital, which meets all six of these requirements:

1. Maintains permanent and full-time facilities for bed care of resident patients; and
2. Has the services of a Physician available at all times; and
3. Has a registered nurse (RN) or Physician on full-time duty who's in charge of patient care, along with one or more RNs or licensed practical nurses (LPNs) on duty at all times; and
4. Keeps a daily medical record for each patient; and
5. Is primarily working to provide continuous skilled nursing care for sick or injured patients during the recovery stage of their illness or injuries and is not, other than incidentally, a rest home or a home for custodial care for the aged; and
6. Is operating lawfully as a nursing home in the area where it is located.

In no event, however, will the term "Skilled Nursing Facility" include an institution that primarily provides care and treatment of substance or alcohol abuse.

Surcharge: The Administrator will charge a Board-approved percentage over the normal rate for a period of six months for a person who will have any portion of the pre-existing waiting period waived due to being accepted for the SCHIP coverage based on paying a rate greater than 150% of the SCHIP base rates.

Surgical Assistant: A Physician who helps the operating Physician with surgery in a Hospital when such help is not available by an intern, resident or house Physician.

Transplant Benefit Period: For an organ, the period begins on the admission date in which a transplant is performed and continues for 12 months. For bone marrow, the period begins on the first date of mobilization therapy, marrow/stem cell harvest date or inpatient admission date for the transplant procedure, whichever occurs first, and will continue for 12 months.

Transplant Lifetime Maximum: The maximum amount of benefits provided in a lifetime for each of the transplants listed in your Policy Data Page. Once the Transplant Lifetime Maximum has been met, no additional transplant benefits will be provided for that type of transplant.

Waiting Period: The period that must pass before you are eligible to be covered for benefits under the terms of this policy. The Waiting Period begins on the day you substantially fill out your application and submit your premiums and ends on the first day of coverage.

GENERAL INFORMATION

Approval for Coverage of Treatment

So you are paid the highest possible allowance for Medically Necessary services, the Administrator must give approval in advance for all Hospital admissions, Skilled Nursing Facility admissions and certain outpatient services. It is your responsibility to obtain these approvals or to make sure appropriate preapprovals are obtained.

If you are undergoing a human organ and/or tissue transplant, you must get written approval from the Administrator in advance. The transplant must also be performed at a facility designated by the Administrator.

Please note that if your request is denied for preauthorization or preapproval for services or benefits, you may request further review under the guidelines set out in the *Appeal Procedures* section of this policy. Also note that a preauthorization and preapproval denial for a service will be considered a denied claim for purposes of appeals and grievances.

There are several kinds of approval: Preadmission Review, Emergency Admission Review, Continued Stay Review and Outpatient Review.

Preadmission Review – You must get Preadmission Review approval before admission to a Hospital or Skilled Nursing Facility. If you don't call for approval and the admission is Medically Necessary, no benefits are paid for any part of room and board charges.

If the admission is not Medically Necessary and you go to the Hospital anyway, no benefits are paid whether or not you call in advance.

Emergency Admission Review – When you have an Emergency Medical Condition and a Hospital admission is required, you or a family member must notify the Administrator as follows (except for reasons beyond your control):

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

If you don't call for approval (except for reasons beyond your control), no benefits are paid for any part of room and board charges even if the admission is Medically Necessary.

If the admission is not Medically Necessary, no benefits are paid whether or not you call for approval.

Continued Stay Review – If you need to be in the Hospital longer than approved by the Administrator, you must call the Administrator for Continued Stay Review. If you don't call for approval, no benefits are paid for any part of Hospital room and board charges for the continued stay even if it is Medically Necessary.

If the continued stay is not Medically Necessary, no benefits are paid whether or not you call for approval.

Medically Necessary Cosmetic Reconstructive Surgery – Your Physician must write to the Administrator in advance for written approval before any policy benefits will be considered. You need to have this approval before surgery is performed for any eligible benefits to be covered.

Outpatient Review – You must get Outpatient Review approval before you receive Home Health Care services, Hospice Care or any of the following outpatient procedures or supplies: chemotherapy or radiation therapy (first treatment only), hysterectomy, septoplasty, sclerotherapy or Durable Medical Equipment (DME) when the purchase price or rental cost is more than the amount shown in your Policy Data Page.

If you don't call for approval and the services are Medically Necessary, benefits will be reduced as shown in your Policy Data Page. If the services are not Medically Necessary, no benefits are paid whether or not you call for approval.

REMINDER

YOU MUST GET YOUR OWN APPROVAL

EMERGENCY MEDICAL CARE BY A NON-NETWORK PROVIDER

If you receive Emergency Medical Care from a Non-network Provider, you will receive benefits for Covered Expenses at the Percent Payable to a Network Provider if all the following conditions are met:

- You were traveling for reasons other than seeking medical care when the Emergency Medical Condition occurred.
- You were treated for an accident or new illness so severe that immediate medical attention was required for severe pain, to save your life or limbs or preserve your ongoing health status.

Benefits under this provision are subject to the non-network Deductibles and Per-occurrence Copayments and all policy maximums, limits and exclusions.

If you have claims that meet all conditions listed above, you should write to the SCHIP address shown in your Policy Data Page. Your claims will be reviewed to determine if benefits can be provided.

HOW BENEFITS ARE PAID

Each Benefit Period, this policy pays the Percent Payable of the Allowable Charge for Covered Expenses after you meet the Deductible or pay the applicable copayment until you meet the Out-of-pocket Expense amount. The Percent Payable and Out-of-pocket Expense are shown on the Policy Data Page.

Covered Expenses not paid by this policy for Psychiatric Care, any Per-occurrence Copayment and the Deductible do not count toward your Out-of-pocket Expense. After you meet the Out-of-pocket Expense, this policy will pay 100% of the Allowable Charge at Network and non-Network Providers for the rest of the Benefit Period (except for Psychiatric Care and the following when the required prior approvals are not obtained: inpatient Hospital admissions, Medically Necessary cosmetic reconstructive surgery, Home Health Care, Hospice Care, human organ and/or tissue transplants, Skilled Nursing Facility admissions and certain outpatient services).

COVERED EXPENSES

IMPORTANT: All Hospital Admissions, Medically Necessary cosmetic reconstructive surgery, Home Health Care, Hospice Care, human organ and/or tissue transplants, Skilled Nursing Facility admissions, certain outpatient services and DME (when the purchase price or rental cost is more than the amount shown in your Policy Data Page) require prior approval from the Administrator (See the *General Information* section of this policy).

Covered Inpatient Hospital Expenses

1. Semi-private room or special care unit (such as burn, heart or intensive care).
2. Operating and recovery rooms.
3. Anesthetics.
4. X-ray and lab services.
5. Prescribed drugs.
6. Blood and blood plasma.
7. Other prescribed Hospital supplies and services.
8. Services in a Skilled Nursing Facility (SNF). The maximum benefits are limited to 60 days per Benefit Period. The covered daily charge may not exceed the Medicaid maximum daily Allowable Charge.
9. Rehabilitative care prescribed by a Physician for 14 days per Benefit Period.

Covered Outpatient Hospital Expenses

1. Treatment of an accident, including lab and X-ray services.
2. Surgery, including lab and X-ray services.
3. Physical, radiation and inhalation therapy and chemotherapy.
4. Diagnostic lab and X-ray services.
5. Treatment of illness if the Hospital admits the patient for further treatment of that illness.
6. Routine mammography for any female Policyholder according to the most recently published American Cancer Society (ACS) guidelines.

The most recently published ACS guidelines, dated July 1, 1998, recommend an annual mammography for women age 40 and over. The ACS guidelines are subject to change. If you have access to the Internet, you can find more details about mammograms and breast cancer or see the latest guidelines on ACS' Web site: www.cancer.org.

Covered Physician Expenses

Charges for professional services for covered Physician expenses for:

1. Treatment of an accident, including lab and X-ray services.
2. Inpatient and outpatient surgery.
Benefits for surgery include payment for pre- and post-operative care.

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

When more than one skin lesion is removed at one time, the Allowable Charge is covered for the biggest lesion, 50% of the Allowable Charge is covered for the removal of the second largest lesion, and 25% of the Allowable Charge is covered for removing any other lesion.
3. Outpatient lab and X-ray services.
4. Surgical Assistant when the operation requires an assistant. Payment is up to 20% of the Allowable Charge for surgery.
5. Obstetrical services for any female Policyholder. The Administrator will provide benefits for the hospitalization and related professional services for the mother and newborn child for at least 48 hours after a vaginal delivery or to the date of discharge from the Hospital – whichever occurs first. This doesn't include the day of delivery. The Administrator will also provide benefits for the hospitalization and attending professional services for the mother and newborn child for at least 96 hours following a Cesarean section or to the date of discharge from the Hospital – whichever occurs first. This doesn't include the day of surgery.
6. Anesthesia administration when done by a doctor who did not do the surgery or deliver a baby. Payment is up to 20% of the Allowable Charge for surgery.
7. Inpatient Hospital and SNF medical (not related to surgery) visits, limited to one visit a day per Physician.
8. Inpatient consultations in a Hospital.
9. Home and office visits that are not part of routine physical exams.
10. Two routine OB-GYN (obstetrical-gynecological) examinations annually, for any female Policyholder.
11. Routine pap smear screenings, one per female Policyholder per Benefit Period, or more often if recommended by a medical doctor.

A pap smear is an examination of cervical cells for the purpose of detecting cancer.
12. Routine prostate exam, screening and lab work according to the most recently published American Cancer Society (ACS) guidelines (Web site: www.cancer.org).

The most recently published ACS guidelines, dated July 1, 1998, recommend that both Prostate-Specific Antigen (PSA) and Digital Rectal Examination (DRE) should be offered annually to men age 50 and over who have at least a 10-year life expectancy, and to younger men who are at high risk.

Men who choose to undergo screening should begin at age 50. However, men in high-risk groups, such as those with a strong familial predisposition (e.g., two or more affected first-degree relatives) or African Americans may begin at age 45. The ACS guidelines are subject to change.

Other Covered Expenses

1. Medical supplies and insulin, if prescribed by a Physician.
2. Ground ambulance service to or from the nearest local Hospital for an Emergency Medical Condition.
3. Outpatient physical therapy services by a licensed, professional physical therapist if prescribed by a Physician. Benefits are limited as shown in your Policy Data Page and include physical therapy received in a doctor's office, rehabilitation facility, outpatient Hospital and with Home Health Care or Hospice Care.
4. Prosthetic appliances; orthopedic lifts, braces and crutches, if needed and prescribed by a Physician.
5. Oxygen and the rental of equipment for using oxygen outside of a Hospital or Skilled Nursing Facility if prescribed by a Physician.

6. Diagnostic lab and X-ray services.
7. Home Health Care if prescribed by a Physician. Benefits are limited as shown in your Policy Data Page.
8. Hospice Care.
9. Human Organ and/or Tissue Transplants. When preapproved by the Administrator and performed by a provider the Administrator designates, benefits are payable for all expenses for medical and surgical services and supplies incurred while covered under this policy for human organ and/or tissue transplants. All benefits provided during a Transplant Benefit Period will apply toward the Transplant Lifetime Maximum. Prescription drugs, however, do not apply toward the Transplant Lifetime Maximum.

Organ transplant coverage includes expenses incurred for donor organ procurement and all inpatient and outpatient Hospital and medical expenses for the transplant procedure. This includes all pre- and post-operative care, including immunosuppressive drug therapy.

- a. The only living donor, human organ transplants covered under this Contract are kidney transplants for Members with dialysis dependent kidney failure and liver transplants. All other living donor, human organ transplants are not covered. Benefits will be subject to the following conditions:
 1. When both the transplant recipient and the donor are Policyholders, benefits will be provided for both;
 2. When the transplant recipient is a Policyholder and the donor is not, benefits will be provided for both the recipient and the donor to the extent that benefits to the donor are not provided by any other source. This includes, but is not limited to, other insurance coverage, any government program or any employee welfare plan. Benefits provided to the donor will be charged against the recipient's coverage under this policy;
 3. When the transplant recipient is not a Policyholder and the donor is, no benefits will be provided to either the donor or the recipient.
- b. Limited benefits are provided for the specified major human organ transplant procedures listed below. These benefits are subject to all other provisions of the policy:
 - Kidney (single or double), liver, heart, heart and lung (single or double), lung (single or double), cornea, pancreas and pancreas/kidney transplants.
- c. Benefits may be available when a malignancy is present for high dose chemotherapy followed by hematopoietic stem support, either autologous (the patient is the donor) bone marrow transplant, peripheral stem cell or allogeneic bone marrow transplant when the procedure is considered Medically Necessary.
- d. Benefits may be available for allogeneic bone marrow transplantation in the treatment of developmental and non-malignant diseases of bone marrow when the procedure is considered Medically Necessary.

Benefits for allogeneic or syngeneic bone marrow transplants as described in items 3 and 4 above are available only if there are at least four out of six histocompatibility complex antigen matches between the patient and the donor and the mixed lymphocyte culture is nonreactive.

- e. Transplants of tissue (rather than whole major organs), except fetal tissue, are Covered Expenses under this policy, subject to all the provisions of this policy only as follows:
 - Blood transfusions (but not whole blood and blood plasma);
 - Autologous parathyroid transplants;
 - Corneal transplants;
 - Bone and cartilage grafting; or
 - Skin grafting.
10. Purchase price or rental cost (up to purchase price) of Durable Medical Equipment.
11. Prescription drugs. Benefits are provided as described in your Policy Data Page. Benefits are available for prescription drugs and medical supplies you buy from a pharmacy. A licensed, registered pharmacist must dispense the prescription drugs.

Non-Participating Network Pharmacies can charge you more than the Allowable Charge. That means you will have to pay more out of your pocket for drugs and supplies purchased at a non-Participating Network Pharmacy.

The Administrator has an agreement with a network of pharmacies to provide prescription drugs and certain medical supplies to each Policyholder at less than the normal retail prices. These pharmacies are called “Participating Network Pharmacies.” When you buy prescription drugs from a Participating Network Pharmacy, you must show the pharmacist your ID card. The pharmacist will know not to charge you more than the Participating Network Pharmacy Allowable Charge.

The Pharmacy Benefit Manager (PBM) for the Administrator and some of its subsidiaries, contracts with and manages the pharmacy network, negotiates prices with the Participating Network Pharmacies and performs other administrative services. The Administrator of the SCHIP program receives a portion of the financial credits directly from drug manufacturers and through the PBM. The credits accrued by the SCHIP plan are used to offset costs of the SCHIP program. 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 due to receipt of any financial credit by the Administrator. Copayments are flat amounts and likewise do not change due to receipt of PBM credits.

Whether you buy drugs or supplies from a Participating or non-Participating Network Pharmacy, you must pay the pharmacy at the time of purchase. To file your claim:

- Use an approved claim form. You can get these forms by calling the number shown in your Policy Data Page or by writing to the address shown in your Policy Data Page.
- Fill out the top half of the form, sign it and attach the receipt.
- Mail the form to the Participating Network Pharmacy Headquarters at the address shown on the form.

Any benefit due will be paid directly to the Policyholder.

12. Psychiatric Care. Payment is limited as described in your Policy Data Page.
13. Medically Necessary care and treatment of a Cleft Lip and Palate and any condition or illness that is related to or caused by Cleft Lip and Palate.

Cleft Lip and Palate means a congenital cleft in the lip or palate or both. Care and treatment will include, but is not limited to these types of Medically Necessary care:

- a. Oral and facial surgery, surgical management and follow-up care;
- b. Prosthetic treatment such as obturators, speech and feeding appliances;
- c. Orthodontic treatment and management;
- d. Treatment and management for missing teeth (prosthodontic);
- e. Ear, nose and throat (otolaryngology) treatment and management;
- f. Hearing (audiological) assessment, treatment and management performed by or under the supervision of a licensed doctor of medicine, including surgically implanted hearing aids; and
- g. Physical therapy assessment and treatment.

If a person with a Cleft Lip and Palate is covered under this policy and is also covered by a dental policy, then teeth capping, prosthodontics and orthodontics will be covered by the dental policy to the limit of coverage provided and any excess after that will be provided by this policy.

14. Hospitalization for at least 48 hours following a mastectomy. If you are released early, benefits will be provided for at least one home care visit if the attending Physician orders it.

Benefits will also be provided for prosthetic devices and reconstruction of the breast on which the mastectomy was performed. This includes surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance as determined in consultation with the attending Physician and the patient.

15. Equipment, supplies and outpatient self-management training, and education for the treatment of Policyholders with diabetes if it’s Medically Necessary, and a healthcare professional prescribes it. This healthcare professional must be legally authorized to prescribe such items and follow minimal standards of care for diabetes. These minimal standards of care are adopted and published by the Diabetes Initiative of South Carolina.

Diabetes self-management training and education will be provided on an outpatient basis when done by a registered or licensed healthcare professional that is certified in diabetes.

Pre-existing Conditions Limitations

SCHIP will not cover any charges or expenses incurred during the first six months after your effective date under this policy for a condition if, during the six-month period immediately before the effective date of coverage:

- The condition would have caused a reasonable person to seek diagnosis, care or treatment; or
- Medical advice, care or treatment was recommended or received for that condition.

The Administrator will waive the pre-existing conditions limitations to the extent that similar exclusions, if any, were satisfied under previous health coverage if you are purchasing this policy because:

1. Your previous health coverage was involuntarily terminated for any reason other than non-payment of premium and you apply within 63 days of termination; or
2. At the time of application for SCHIP, the premium for your current similar Health Insurance is greater than 150% of the SCHIP rate.

The pre-existing conditions limitations waiver does not apply to a person when the previous policy was terminated or rescinded involuntarily because of material misrepresentation.

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

Federally Defined Eligible Individual – The pre-existing condition limitations will be waived for a Federally Defined Eligible Individual.

Qualified TAA Eligible Individual – The pre-existing condition limitations will be waived for a Qualified TAA Eligible Individual if the person had creditable coverage for a total period of three months as of the date when the person seeks to enroll in SCHIP, not counting any period prior to a 63-day break in coverage.

SERVICES AND SUPPLIES NOT COVERED

Some services and supplies you may get will not be covered under this policy. Benefits are not provided for the following:

1. Room and board charges in any Hospital or Skilled Nursing Facility when the required approval is not obtained as stated in this policy.
2. When you don't get the required preapproval on certain outpatient procedures, Home Health Care services, Hospice Care and DME, benefits will be reduced as shown in your Policy Data Page.
3. Services, supplies or items that are not Medically Necessary or not specifically listed as a covered benefit under this policy.
4. Services, supplies or treatment you received before you had coverage under this policy or that you receive after you are no longer insured under this policy, except for coverage, if any, provided in the *Termination Provision*.
5. Care provided by the Department of Veterans Affairs (VA) for service-related disabilities.
6. Services not charged to you in Hospitals or by agencies.
7. Hospitalization mainly for diagnostic purposes unless such tests require admission to a Hospital.
8. Inpatient admission for the sole purpose of receiving physical therapy.
9. Treatment or tests you receive as an inpatient that could have been done safely as an outpatient.
10. Any amount for Covered Expenses paid or payable through any other Health Insurance or health coverage.
11. All hospital or medical expense benefits paid or payable under workers' compensation (a settled workers' compensation claim is considered paid under workers' compensation), automobile medical payment or liability insurance whether provided on the basis of fault or nonfault.
12. All hospital or medical expense benefits paid or payable under or provided according to any state or federal law or program.
13. Services and supplies related to human organ and/or tissue transplants when preapproval from the Administrator is not obtained and/or services and supplies are not obtained from a provider the Administrator designates.

14. Human organ and/or tissue transplant procedures not specifically listed in this policy.
15. Surgical or medical care related to animal organ transplants, animal tissue transplants, artificial organ transplants or mechanical organ transplants.
16. Investigational or Experimental Services including, but not limited to, the following:
 - Uses of allogenic or syngeneic bone marrow transplants or other forms of stem cell rescue (with or without high dose chemotherapy or radiation) in cases in which less than four of six complex antigens match; cases in which mixed leukocyte culture is reactive; and Acquired Immunodeficiency and Human Immunodeficiency Virus infection;
 - Adrenal tissue to brain transplants;
 - Islet cell transplants;
 - Dorsal Rhizotomy in the treatment of spasticity;
 - Procedures that involve the transplantation of fetal tissues into a living recipient.
17. Medical care by a Physician other than the attending Physician during a Hospital admission unless a medical specialist is needed for a condition the attending Physician couldn't treat.
18. Routine physical exams, hearing exams, eye exams (including eye refractions), Hospital nursery charges and the first medical exam of a newborn well baby, well baby care and immunizations.
19. Services and supplies related to cosmetic surgery. This means any plastic or reconstructive surgery done mainly to improve the appearance of any body part, and from which no improvement in physiologic function is reasonably expected, unless performed either to correct functional disorder or as a result of an injury. Cosmetic surgery excluded includes, but isn't limited to:
 - Surgery for sagging or extra skin;
 - Any augmentation or reduction procedures;
 - Rhinoplasty and associated surgery; and
 - Any procedures using an implant that doesn't alter physiologic function or isn't incidental to a surgical procedure.
20. Custodial or intermediate care. This is care meant simply to help people who cannot take care of themselves.
21. Acupuncture.
22. Treatment of obesity or weight reduction, including any surgical procedures specifically designed to treat obesity and any complications arising from such treatment, other than gastric bypass and gastric stapling when Medically Necessary for the treatment of morbid obesity.
23. Hospital charges for dental treatment and any related services and complications.
24. Physician services directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. This includes but is not limited to: apicoectomy (dental root resection), root canal treatment, the excision or extraction of impacted teeth, alveolectomy and treatment of gum disease.
25. Services or supplies related to dysfunctional conditions of the chewing muscles, malpositions or deformities of the jaw bone(s), orthognathic deformities or temporomandibular joint syndrome.
26. Treatment resulting from war or acts of war (whether declared or undeclared); while in the military service or its auxiliary units.
27. An illness you get or injury you receive from participating in a riot or uprising, while committing a crime, felony or misdemeanor, or while engaged in an illegal occupation.
28. Educational, occupational, rehabilitative, recreational or speech therapy except as covered in the 14 days annual limit for rehabilitative care described under *Covered Inpatient Hospital Expenses*.
29. Any type of rehabilitative care for alcohol, drug or other substance abuse.
30. Surgery to correct refractive errors, eyeglasses, contact lenses except after cataract surgery, hearing aids and examinations for their fitting.
31. Prescribed drugs you take home from a doctor's office, Hospital or Skilled Nursing Facility.

32. Prescribed drugs used for or related to birth control, weight control, obesity, cosmetic purposes, smoking cessation, hair growth or fertility.
33. More than a 34 consecutive day supply for prescription drugs dispensed by prescription except for 100 unit doses for thyroid products, nitroglycerin, digitalis leaf and alkaloids.
34. Any type of service charge, including the administration or injection of a prescription drug.
35. Devices of any type (even though dispensed by prescription) including, but not limited to, contraceptive devices, therapeutic devices, artificial appliances or similar devices.
36. More than recommended daily dosage of any prescription drug as described in the current *Physician's Desk Reference* or prescription drug refills beyond one year from the original prescription date.
37. Over the counter supplies including, but not limited to: appliances, bandages, devices, sundries, non-prescription drugs, infant formula and food supplements, even if a Physician prescribes it.
38. Private duty nursing services in a Hospital or Skilled Nursing Facility by licensed practical nurses (LPNs), registered nurses (RNs), sitters or companions.
39. Services or care used to detect and correct by manual or mechanical means, structural imbalance, distortion or subluxation in your body for the purpose of removing nerve interference and its effects when this interference is the result of or related to distortion, misalignment or subluxation of or in the spinal column.
40. Anesthesiology by the doctor who performs the patient's surgery or who delivers a baby.
41. Any expense or charge for sex change or any treatment related to sexual dysfunction.
42. Any expense or charge for the promotion of fertility including, but not limited to:
 - a. fertility tests;
 - b. reversal of surgical sterilization; and
 - c. any attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer or any similar treatment or method.
43. Care of bunions unless corrected by a surgical procedure; care of corns, callouses, nails of the feet, flat feet, fallen arches, chronic foot strain or symptomatic complaints related to the feet.
44. Any services provided by a relative. A relative means the spouse, parent, grandparent, brother, sister, child or in-law.
45. Services or supplies for which you are not legally obligated to pay.
46. Any intentionally self-inflicted injury or illness, whether sane or insane.
47. Services or supplies not performed or prescribed by a Physician.
48. Travel, luxury or convenience items, even if a Physician recommends it.
49. Advice or consultation given by or through any form of telecommunication, such as a telephone consultation or virtual office visit via the Internet.
50. Charges for completion of any insurance form or as the result of a missed appointment.
51. Any service or treatment for complications resulting from any non-covered procedures.

RENEWAL AND TERMINATION AGREEMENT

Your policy will be renewed for one month each time you pay the required premium by the due date or within the 31-day grace period until the earliest of the following dates:

1. The next premium due date following the date you are no longer eligible according to the rules under the Eligibility section;
2. The date you request the policy to end;
3. The date South Carolina statutes require cancellation of the policy;

4. The date of any fraudulent act as determined by the Board. In the case of material misrepresentation in application, the policy will be rescinded as of the effective date of coverage;
5. The date that the Board determines that your premium, Deductible or Coinsurance amount is being paid or reimbursed by a healthcare provider, health agency, health entity, public or private institution, or any other person or entity which does not have an insurable interest in the applicant or Policyholder.

GENERAL POLICY PROVISIONS

1. **Certification:** When your coverage under this policy ends, you have the right to receive a certification showing the period of coverage you had under this policy. This period of coverage is called Creditable Coverage. It may be that credit for the period of this coverage will be given, if a future employer with a group Health Insurance plan has a pre-existing condition exclusion period, so long as there is no more than a 63-day break in coverage between this coverage and any succeeding coverage. You may also request a Certificate of Creditable Coverage from the Administrator even if your coverage is still in force. To request the Certificate of Creditable Coverage, please write or call the Administrator at the address or phone number shown on your Policy Data Page.
2. **Claim Forms:** If you need a claim form, contact the Administrator. If you do not receive this form within 15 days, you will meet the proof of loss requirements by sending the Administrator copies of bills or statements showing the diagnosis, treatment or other procedures, which are the basis of your claim. You will need to provide this documentation within the time limits stated in the policy.
3. **Conformity with Statutes:** Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which you reside on that date is amended to conform to the minimum requirements of such laws.
4. **Entire Policy; Changes:** The policy, your enclosed application and any amendments, riders or endorsements make up the whole policy between you and SCHIP. No change in this policy is valid unless it comes to you as an amendment, rider or endorsement from SCHIP. No agent has the authority to change this policy or to waive any of its provisions. The Board can amend benefits from time to time at its discretion, subject to approval by the South Carolina Department of Insurance.
5. **Grace Period:** Unless SCHIP has told you of its intent not to renew this policy, the following information about the grace period applies to this policy.

If you do not pay your premium by the date it is due, the Administrator gives you a grace period. The grace period is 31 days from the premium due date. This policy remains in force during the grace period.

However, you must pay SCHIP the premium due during the grace period. SCHIP may collect any unpaid premium by deducting it from any claims payment due to you. If you do not pay your premium by the end of the grace period, your policy is cancelled as of the end of the grace period.

6. **Legal Actions:** You may not bring legal action against SCHIP until 60 days after it has received a claim (notice and proof of loss). You cannot bring any such action against SCHIP more than six years after it received a claim.
7. **Notice of Claims and Proofs of Loss:** You must give written notice of a claim to SCHIP within 90 days after a covered loss starts or as soon as reasonably possible. Notice given by or on behalf of the Policyholder to SCHIP with information sufficient to identify the Policyholder will be deemed notice to SCHIP. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event, except in the absence of legal capacity, will written proofs of loss be furnished later than one year from the time proof is otherwise required.
8. **Other Valid Coverage:** This policy is not meant to duplicate other valid coverage you have with other insurance policies. "Other valid coverage" is Health Insurance Coverage that is similar to the coverage provided by this policy, coverage provided by union welfare plans or employee benefit organizations.

If you obtain comparable Health Insurance from any other source, you are no longer eligible for this policy and it will not be renewed. SCHIP will reduce any benefit it would normally pay by the amount you receive from any other sources for the same expense. These other sources include other Health Insurance or health coverage, workers' compensation coverage, medical payment or liability insurance (fault or no fault), and any state or federal law or program.

9. **Payment of Claims:** All benefits provided in this policy will be paid promptly upon receipt of due proof of loss. Without assignment of benefits to the provider of services, payments will, at the option of the Administrator, be made either directly to the Policyholder or the provider of the service.

10. **Physical Examinations:** SCHIP may require a physical exam, at its expense, of any Policyholder as often as is reasonable to settle claims.
11. **Right to Recovery:** SCHIP may recover any amounts paid in benefits that were not Covered Expenses or were paid in error. SCHIP may reduce the amount recoverable by SCHIP from any future benefits payment.
12. **Subrogation Rights:** SCHIP may subrogate if:
 - a. A claim is made to SCHIP for an illness or injury that results in charges under this policy; and
 - b. SCHIP believes a third party is liable and reasonably expects the third party will reimburse you for those charges. SCHIP will succeed to individual rights of recovery against such third party to the full extent of the amount of benefits paid by SCHIP. You should, at SCHIP's request, give SCHIP any information it may need and sign any documents that may be required to assist SCHIP in recovering this amount, and do nothing to prejudice SCHIP's subrogation rights. SCHIP will pay its portion of attorney fees and costs incurred in pursuing its subrogation recovery.

You have the right to petition the Director of the South Carolina Department of Insurance, or his designee, to determine if SCHIP's subrogation action is inequitable or unjust.

Subrogation means that SCHIP is allowed to recover the amount of medical benefits it has paid at the time you settle a lawsuit or a judge or jury awards you money resulting from an accident.

13. **Time Limit on Certain Defenses:** It is possible to make a mistake in filling out an application for an insurance policy. During the first two years this policy is in force, SCHIP cannot deny a claim because of an error in your application, unless your error misled SCHIP about the risk it assumed when the application was accepted. If your error on the application was misleading in this manner, SCHIP may have grounds to void the policy. In this case, SCHIP will refund your premium, less any benefits paid for claims you have had.

After two years from the issue date, the validity of the policy may not be contested except that fraudulent misstatements in your application may be used to void the policy or deny any claims for loss incurred or disability that starts after the two-year period.

TIME LIMIT TO FILE A CLAIM

There is a deadline for filing claims. The Administrator must receive your claim, provider's bill and/or receipt by the end of the following year in which you received the services or supplies. So, if you saw a Physician on May 15, 2004, the Administrator must receive the completed claim by December 31, 2005.

HOW TO GET HELP FROM THE SOUTH CAROLINA HEALTH INSURANCE POOL

If you change your address or need information about your Health Insurance, call the number listed in your Policy Data Page.

If you can't call, write to the address shown in your Policy Data Page.

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

APPEAL PROCEDURES

If you disagree with a decision made on a claim, you may appeal the decision to the SCHIP Review Committee. You may request an "Appeal Request Form" from SCHIP or by calling the number or writing to the SCHIP address shown in your Policy Data Page.

A preauthorization and preapproval denial for a service will be considered a denied claim for purposes of this provision. Any complaints or disagreements you have regarding a preauthorization and preapproval may be directed to the Administrator by calling the number under approvals shown in your Policy Data Page.

You should attach any additional medical records or other information that you feel may have a bearing on your appeal. You should also state why you disagree with the decision made on your claim.

The SCHIP Review Committee will notify you in writing of their decision within 60 days from the date they receive your request for appeal. If the committee needs to request medical records, you will be notified no later than 120 days after your request for appeal.

If you are still not satisfied with the SCHIP Review Committee's decision, you may request an appeal. You have 30 days after you receive the SCHIP Review Committee's decision on the formal grievance to request an appeal. Send your request for an appeal to the SCHIP Review Committee, at the SCHIP address shown in your Policy Data Page.

External Reviews

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

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

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

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

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

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

Expedited External Reviews

If your Physician certifies that you have a "serious medical condition," you are entitled to an expedited external review. A serious medical condition, as used in this provision, is one that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place your health in serious jeopardy.

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

CONTINUATION OF CARE

If a Network 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 the time a Network 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 the Administrator on the appropriate form.

You may get the form for this request from the Administrator by going to their website at www.SouthCarolinaBlues.com or calling 803-264-3475 in Columbia or 800-868-2500, ext. 43475 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, the Administrator will notify you and the provider of the last date the provider is part of the Administrator's network and a summary of continuation of care requirements. The Administrator will review your request to determine if you qualify for the continuation of care. If additional information is necessary to make a determination, the Administrator may contact you or the provider for such information.

If the Administrator approves your request, the Administrator 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 policy, 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.

SOUTH CAROLINA HEALTH INSURANCE POOL