



# PRODUCER'S GUIDE

A Guide to BlueChoice HealthPlan's Products and Services



**[BlueChoiceSC.com](http://BlueChoiceSC.com)**

BlueChoice HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association.

# Welcome

Thank you for choosing BlueChoice HealthPlan for your clients. We designed this Producer's Guide to help you understand the procedures for our products. It will help you become knowledgeable about our policies and procedures. If you have any questions about these policies, please refer to your group's contract, consult your marketing representative or call Marketing Support. Please use this guide as a reference. As we add to or revise our policies and procedures, we will update the appropriate section(s) of the Producer's Guide on [www.BlueChoiceSC.com](http://www.BlueChoiceSC.com). We always welcome your suggestions and feedback on ways we can improve our service. Thank you for your continued interest in BlueChoice HealthPlan. We look forward to doing more business with you.

**Marketing Support: 866-280-0766**

## Key Points to Remember

- Please run all proposals for CarolinaADVANTAGE through our Web-based Accel-A-Rate<sup>SM</sup> program.
- All agents must be licensed and appointed to sell BlueChoice HealthPlan products before they can sell a group.
- For information about CarolinaADVANTAGE, our small group coordinators are available by calling Marketing Support at 866-280-0766 or 803-382-5976.
- You can also contact your CarolinaADVANTAGE or large group marketing representative; our director of Sales; or the CarolinaADVANTAGE sales manager by calling the Marketing department at 800-327-3183.

# BlueChoice HealthPlan

## BlueChoice HealthPlan Contacts

### CarolinaADVANTAGE (2–50 employees)

- Marketing Support – 866-280-0766 (382-5976 – Local)
- CarolinaADVANTAGE Marketing Representatives – Renewals
  - Melissa Gimbel (Midlands/Upstate) – 803-382-5249
  - Rhonda Hays (Lowcountry) – 843-324-6567
- CarolinaADVANTAGE Sales Manager
  - Paul Povey – 803-382-5210

### Underwriting (for quotes or rating)

- Ernest Robinson (Underwriter) – 803-382-5212
- Cornell Grant (Underwriter) – 803-382-5216
- Amy Gamache (Underwriter) – 803-467-7450
- Donna Webster (Underwriter, BlueChoice<sup>SM</sup> Individual Coverage) – 803-382-5217
- Cheryl Ellison (Underwriter, BlueChoice Individual Coverage) – 803-382-5052
- Tara Bennett (Manager) – 803-382-5422

### Billing

- Marketing Support – 866-280-0766

### Licensing and Commissions

- Cheryl Brinchi – 803-264-4126
- Kim Lentz – 803-264-5267
- Jaime Orvin – 803-264-2969

### Member Services

- Toll free – 866-858-3272
- Local (Columbia, S.C.) – 803-382-5975
- [www.BlueChoiceSC.com](http://www.BlueChoiceSC.com)

### Marketing

#### - Large Group (51+ employees) and Small Group (2–50 employees) Sales

- **Marketing Representatives:**
  - Rhonda Hays (Charleston/Lowcountry) – 843-324-6567
  - Frank McGill (Upstate/Greenville) – 864-770-3319 (cell) or 803-382-5539 (office)
  - Jay Holloway (Upstate/Greenville) – 803-382-5549
  - Greg Sullivan (Midlands/Upstate) – 803-382-5354
  - Jennifer Swegle (Large Group Key Accounts) – 803-235-6027 (cell) or 803-382-5573 (office)
  - Lisa Barrett (Sales Director) – 803-382-5508
  - Dave Krupa (Vice President) – 803-382-5531

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### - Large Group Renewals (51+ employees)

- **Marketing Representatives:**
  - o Donna Arndt – 803-382-5469
  - o Chris Bass – 803-382-5878
  - o Ann Getman – 803-382-5467
  - o Kim Hite – 803-382-5352
  - o Nancy Roberts – 803-382-5462
  - o Rhonda Swindler – 803-382-5592
  - o Fern Kelly (Manager of Account Services) – 803-382-5464
  
- **For information concerning communications or marketing materials:**
  - o Mee Jean Sasine (Marketing Communications Specialist) – 803-382-5252
  - o Dionne Robinson (Project Coordinator) – 803-382-5568

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# **SECTION 1**

## **Benefits and Coverage**

### 1.1 CarolinaADVANTAGE

### 1.2 Primary Choice, BlueChoice Point of Service, BlueChoice ADVANTAGE Plus

## Section 1 Benefits and Coverage

### 1.1 CarolinaADVANTAGE – Small Group (2–50)

**CarolinaADVANTAGE** is an open-access Point of Service plan for groups with **2–50** employees. We do not require members to select a primary care physician when they enroll in the plan. But we encourage them to do so. “Open access” means members have benefits when they visit any doctors they choose. They don’t need referrals from physicians. “Point of service” means members decide at the time they need medical services whether to use a doctor within our statewide network or seek medical care outside the network.

### Navigating the Networks

#### *In Network*

Many benefits are available only when members receive them from health care professionals in our network. Some examples are preventive care services, routine health screenings, and well-baby and well-child care. While not required, we suggest that members select primary care physicians who can help coordinate their health care. Benefits for other covered services are available at a higher level of coverage when members stay in the network. For this higher level of coverage, members simply visit participating physicians, hospitals and other network providers.

There are other advantages to using in-network doctors. These doctors will:

- File claims for covered expenses for members.
- Ask members to pay only the copayment, deductible and coinsurance amounts, if any, for covered expenses.
- Accept our payment as payment in full for covered expenses, minus the out-of-pocket expense, if any.

#### *Out of Network*

With **CarolinaADVANTAGE**, members can enjoy the flexibility of visiting the doctors of their choice — even if they aren’t in our network. The out-of-pocket costs will be a little more. This is because members may have to pay a copayment, deductible, coinsurance and all charges above our allowable charges. They may also have to file their own claims. We may not cover some services, such as preventive care services, if the member goes outside the network.

Members can seek emergency care from out-of-network hospitals or doctors and still receive the in-network level of benefits. If members have a life- or limb-threatening illness or injury, they should go to the nearest hospital or treatment center. This is regardless of whether or not it is in the network. We do ask that the member or a family member inform us about the emergency as soon as possible.

**For more details on benefits and coverage, please refer to the *Master Group Contract and Schedule of Benefits*.**

# BlueChoice HealthPlan

## 1.2 Primary Choice, BlueChoice Point of Service, BlueChoice ADVANTAGE Plus – Large Group (51+)

**Primary Choice** is a health maintenance organization (HMO) plan. Network primary care physicians provide or coordinate all health care services covered under the member's plan. The member's primary care physician is the physician he or she selects from our statewide network. When the member needs to see a specialist or other health care professional, his or her primary care physician will refer the member to one in our network. The member will get an authorization stating what services are approved. We'll cover those health care services according to that group's contract.

### Navigating the Networks

#### *In Network*

The member will receive benefits for covered services only when he or she receives those services from participating physicians, hospitals and other health care professionals. That's because there are many benefits to using in-network doctors. We want to make sure our members take advantage of these benefits.

One benefit is access to network doctors. Primary care physicians in our network are available 24 hours a day, seven days a week. If the member's personal doctor isn't available, he or she arranges for another doctor to take care of the member.

There are other advantages to using in-network doctors. These doctors will:

- File claims for covered expenses for the member.
- Ask the member to pay only the copayment, deductible and coinsurance amounts, if any, for covered expenses.
- Accept our payment in full for covered expenses, minus the out-of-pocket expense, if any.

#### *Out of Network*

Services the member receives from out-of-network providers are covered under this plan for emergency medical conditions. If the member has a life- or limb-threatening illness or injury, he or she needs to go to the nearest hospital or treatment center. This is regardless of whether or not it is in the network. We do ask that the member or a family member tell his or her primary care physician and us about the emergency as soon as possible.

**BlueChoice Point of Service** is a traditional Point of Service (POS) plan. When the member needs medical services, he or she decides whether to go to a provider within our statewide network or look for medical care outside the network. The member's decision determines the benefit levels.

# BlueChoice HealthPlan

## Navigating the Networks

### *In Network*

Some benefits are available only when the member receives them from health care professionals in our network. Some examples are preventive care services, routine health screenings, and well-baby and well-child care. Benefits for other covered services are available at a higher level of coverage when the member uses network doctors and is referred by his or her primary care physician. Otherwise, we will pay a lower level of benefits.

To take advantage of the savings the network offers, the member must select a participating primary care physician who coordinates all health care services covered under his or her plan. The member has access to his or her primary care physician 24 hours a day, seven days a week. If the member's doctor isn't available, he or she arranges for another doctor to take care of the member.

When a member needs to see a specialist or other health care professional, his or her primary care physician will refer the member to one of our network providers. The member will get an authorization stating what services are approved. Then we'll cover those health care services according to the group's contract.

There are other advantages to using in-network doctors. These doctors will:

- File claims for covered expenses for the member.
- Ask the member to pay only the copayment, deductible and coinsurance amounts, if any, for covered expenses.
- Accept our payment in full for covered expenses, minus the out-of-pocket expense, if any.

### *Out of Network*

With **BlueChoice Point of Service**, a member can enjoy the flexibility of visiting the doctors of his or her choice — even if they aren't in our network. The out-of-pocket costs may be a little more. This is because the member may have to pay higher copayments, deductibles and coinsurance. A member also may have to file his or her own claims. Some services, such as preventive care services, may not be covered if members go outside the network. Please see the *Schedule of Benefits* for more information about covered services.

Members may seek emergency care from out-of-state network hospitals or doctors and still receive the in-network level of benefits. If a member has a life- or limb-threatening illness or injury, the member should go to the nearest hospital or treatment center. This is regardless of whether or not it is in the network. We do ask that the member or a family member tell the primary care physician and us about the emergency as soon as possible.

**BlueChoice ADVANTAGE Plus** is an open-access Point of Service (POS) plan. "Open-access" means members have benefits when they visit any doctors they choose. They don't need referrals from primary care physicians. When the member needs medical services, he or she decides whether to go to a provider within our statewide network or look for medical care outside the network.

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## Navigating the Networks

### *In Network*

Some benefits may be available only when the member receives them from health care professionals in our network. Some examples are preventive care services, routine health screenings, and well-baby and well-child care. Benefits for other covered services are available at a higher level of coverage when the member uses network doctors.

There are other advantages to using in-network doctors. These doctors will:

- File claims for covered expenses for the member.
- Ask the member to pay only the copayment, deductible and coinsurance amounts, if any, for covered expenses.
- Accept our payment in full for covered expenses, minus the out-of-pocket expense, if any.

### *Out of Network*

With **BlueChoice ADVANTAGE Plus**, a member can enjoy the flexibility of visiting the doctors of his or her choice — even if they aren't in our network. The member's out-of-pocket costs may be a little more. This is because the member may have to pay higher copayments, deductibles and coinsurance. The member may also have to file his or her own claims. Some services, such as preventive care services, may not be covered if a member goes outside the network. Please see the *Schedule of Benefits* for more information about covered services.

The member may seek emergency care from out-of-state network hospitals or doctors and still receive the in-network level of benefits. If a member has a life- or limb-threatening illness or injury, the member should go to the nearest hospital or treatment center. This is regardless of whether or not it is in the network. We do ask that the member or a family member tell his or her personal physician and us about the emergency as soon as possible.

# **SECTION 2**

## **Getting a Proposal**

2.1 Small Group (2–50)

2.2 Large Group (51+)

## BlueChoice HealthPlan

### 2.1 Small Group (2–50)

#### **Accel-A-Rate<sup>SM</sup>**

CarolinaADVANTAGE allows agents to quote small groups right away with Accel-A-Rate. This is our automated Web-based rating system for groups with 2–50 employees. You'll find a direct link to this rating system under the agents section of [www.BlueChoiceSC.com](http://www.BlueChoiceSC.com).

Before we grant access to Accel-A-Rate, agents must be licensed to sell BlueChoice HealthPlan products. They must also be affiliated with a general agency or personal producing general agency.

Agents can request access to Accel-A-Rate from their marketing representatives. Once we approve a request, we will issue an ID for the agent to use.

#### **CarolinaADVANTAGE Renewals**

Our marketing representatives mail copies of the CarolinaADVANTAGE renewal to the general agency, the agent and the group. If a group agrees to renew its coverage with the current renewal, it does not need to sign or return anything. If a group wishes to make a plan change, the agent or agency can run alternate benefit plans in Accel-A-Rate. Or, the agent can contact his or her CarolinaADVANTAGE marketing representative and request the desired alternate plans. If the group decides to change benefit plans, Underwriting will need a signed copy of the renewal rate sheet no later than noon the day before the effective date.

## Forms

### **CarolinaADVANTAGE Enrollment Application (Appendix A)**

- Each employee fills out this application for new coverage.
- Groups of 2–19 employees must have each employee fill out a Personal Health Statement (Appendix B).

### **Master Group Application (Appendix C)**

- There should be one Master Group Application filled out for each group. The Master Group Application is the basis for the group contract.

### **Agent New Group Checklist (Appendix D)**

- This form lists all of the information needed for a complete submission to Underwriting.
- Please note that if any of the items on the checklist are incomplete or missing, it may delay the processing of the group.

### **Small Group Request for Coverage (Appendix E)**

- This is the group data form that must be completed before the group can be set up.

### **Companion Life Group Application (Appendix F)**

- Groups of 20–50 must complete the four-page group application.

Companion Life is a separate company that does not offer BlueChoice HealthPlan products. These products are offered by Companion Life, not BlueChoice HealthPlan. BlueChoice HealthPlan has no responsibility for these products.

### **Companion Life Employer Participation Application (Appendix G)**

- Groups of 2–19 must complete the one-page group application.

### **CarolinaADVANTAGE Brochure (Appendix H)**

- This is the informational brochure that lists all the small group plans.

### **CarolinaADVANTAGE Comprehensive Dental Insert (Appendix I)**

- This insert outlines the dental coverage option available for small employer groups.

### **Underwriting Summary Sheet (Appendix J)**

- This sheet gives underwriting guidelines and quick answers to questions that are frequently asked about underwriting small groups.

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## Underwriting Guidelines

### **EFFECTIVE DATES:**

- The effective dates are the first and the 15th of the month. Submit all cases at least two weeks before the effective date.

**All new hires must enroll on the first or the 15th of the month after they complete the waiting period. This must correspond with the group's effective date.**

### **PRODUCT ADMINISTRATION (2–50):**

- Preventive dental, maternity and chiropractic care are standard benefits on all standard plans. They cannot be removed.
- There are no dollar limits or age limits on preventive/wellness care. The mammogram age limits follow the standard for the American Cancer Society unless medically necessary.
- Groups of 2–19 will be age/gender-rated (# based on full-time eligible employees, not the # enrolled).
- Groups of 20–50 will be composite-rated (# based on full-time eligible employees, not the # enrolled).
- Personal health statements are not required on groups with 20 or more full-time eligible employees. This is regardless of the number enrolled.
- If a new hire will be eligible to enroll within 90 days of the initial effective date, he or she must complete an enrollment form. And, if required of the other employees, the new hire must complete a personal health statement.
- An employee must complete a waiver of enrollment form if he or she is waiving medical, medical/dental or life coverage.
- There is a 15 percent surcharge if the group does not supply proof of having workers' compensation coverage. We require a copy of the workers' compensation declaration page. This is if the group does not disclose the workers' compensation carrier's name and policy number on the Small Group Request for Coverage form.
- Contract or leased (1099) employees are not eligible.
- We do not accept management (class) carve-outs of any kind.

### **CONTRIBUTION LEVELS:**

- The minimum employer contribution level is 50 percent of the Single medical premium rate.

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### **PARTICIPATION LEVELS:**

- If the employer pays 100 percent of the Single medical, medical/dental or life premium rate, 100 percent participation in the respective coverage is required regardless of group size.

<b>Eligible Employees:</b>	<b>Minimum Participation Requirements:</b>
2–3	No waiver
4–7	1 waiver
8–12	3 waivers
13–16	4 waivers
17–19	6 waivers
20+	60% of total, full-time eligible employees

### **WAITING PERIODS:**

- The waiting periods of 180 and 365 days are for groups with high employee turnover, such as hotels, restaurants, etc.
- We will not waive the waiting period for any new employee after the original effective date, regardless of the reason.

<b>Eligible Employees:</b>	<b>Waiting Period Options:</b>
2–6	90 or 180 Days
7–19	30, 60, 90 or 180 Days
20–50	30, 60, 90, 180 or 365 Days

### **LIFE INSURANCE:**

- **A minimum of \$10,000 group life and Accidental Death and Dismemberment (AD&D) insurance is required.**

<b>Eligible Employees:</b>	<b>Increments:</b>
2–19	\$10,000 \$15,000 \$20,000 \$30,000 \$40,000 \$50,000
20–50	\$10,000 \$15,000 \$20,000 \$25,000 \$30,000 \$35,000 \$40,000 \$45,000 \$50,000

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- Companion Life will underwrite and bill directly for all amounts over \$50,000.
- Employees may waive the life insurance if they are waiving medical and dental coverage, as long as the employer is not paying the full cost of the life insurance.
- If the employee elects only life insurance, he or she must complete the life section of the enrollment form.
- Dependent Life may be sold with Basic Life. Both are flat amounts based on group size.
- The life insurance election **does not** have to match the medical/dental election. The employee can elect to have Dependent Life (if the employer offers it), but only elect Single medical/dental coverage. Also, the employee can waive the Dependent Life, but elect to cover his family under the medical/dental plan.

### COVERAGE OPTIONS

If the group offers Comprehensive Dental coverage, the employee's dental election must match his or her medical election as to persons covered or coverage waived.

### 2–3 PERSON GROUPS

- If a husband and wife are the only two employees in a legitimate group, they must enroll on separate enrollment forms. They can only enroll the children under one parent.
- If the group has three or more employees and two of those are a husband and wife, they can enroll on one enrollment form with employee + spouse or family coverage.
- The employee that is being covered as a spouse must complete a waiver enrollment form for medical/dental. The covered spouse still has the option of electing the employee life insurance. If elected, he or she must complete the life section on the enrollment form.

### MISCELLANEOUS

- Maximum **Medical** Surcharge is 66.5 percent.
- For groups with employees out of state, send a request to Underwriting to load the out-of-state factor into Accel-A-Rate. Please do this **before** releasing the proposal. Load factors are non-negotiable.
- A group is eligible for coverage if:
  - A legitimate employer is domiciled in South Carolina.
  - At least 25 percent of its eligible employees reside in South Carolina.
- Dependent children can be covered up to age 26.
- Pre-Existing Conditions – There is a look-back period of six months before the employee's hire date for any pre-existing conditions. We will not cover the member's condition if he or she received medical advice or treatment for that condition during the six months immediately before the hire date. We will also not cover the subsequent 12 months. But we will waive the pre-existing condition clause if the member:

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- Has had 12 months of continuous creditable coverage.
- Provides a valid HIPAA Certificate of Creditable Coverage to us.
- Late Entrant Policy – We will exclude the prospective member from coverage for the first 12 months. Then, the member’s coverage will be subject to the pre-existing clause for the subsequent six months.
- Participation (Par) Audits — We require these on existing businesses. Failure to complete and return these could result in termination of the group.

## 2.2 Large Group (51+)

### Getting a Proposal

To get a proposal for any product in the 51+ market, contact your marketing representative (pages 2 and 3). When we receive the information we need for underwriting, the turnaround time is typically four to seven days. For larger cases with multi-years worth of claims experience, the turnaround time could be longer. We will make every effort to provide you a complete proposal within a very reasonable time frame. Our standard underwriting requirements for large groups are as follows:

- Census data (including age, sex, date of birth and coverage type)
- Location of group (including ZIP codes if requesting out-of-state coverage)
- Copy of current plan design
- Employer contribution levels
- New hire waiting periods
- Current and/or renewal rates
- Supplemental claims form
- Two years worth of claims experience (if available)
- Requested plan design

### Renewals

Your account service representative is responsible for providing you with your renewals at least 30 days before the effective date. Your groups will need to provide Participation (Par) Audits at the time of renewal. This will ensure the total number of eligible employees within the groups. Once the groups accept the renewal rates and agree to offer BlueChoice HealthPlan for their next benefit periods, they will need to submit Master Group Contracts for signature for the new benefit periods.

## **SECTION 3**

### **Membership Enrollment and Changes**

3.1 Enrollment

3.2 Changes

3.3 Qualifying Events

3.4 ID Card and Benefit Information

3.5 Health Insurance Portability and Accountability Act  
(HIPAA)

3.6 Termination of Group Contract

3.7 Termination of Employee Contract

3.8 COBRA

3.9 Conversion to Non-group Policy

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## Section 3 Membership Enrollment and Changes

### 3.1 Enrollment

Eligible new employees and their family dependents can elect BlueChoice HealthPlan coverage. Coverage begins when the employee becomes eligible for that group's health benefits. BlueChoice HealthPlan must also receive and approve the enrollment form. The group administrator should submit an Application and Change form within 31 days of the date the employee becomes eligible for coverage. Some groups require a probationary period for new employees. If so, the group administrator can submit the form 31 days in advance of the effective date of coverage. The 31-day deadline also applies when making changes for a current member with a qualifying event.

Agents should supply the group administrator with enrollment materials. These may include:

- A BlueChoice HealthPlan brochure
- Application and Change forms\*
- Schedule of Benefits
- A current BlueChoice HealthPlan provider directory\*
- Other pieces as required

\*You can find this information and download forms at [www.BlueChoiceSC.com](http://www.BlueChoiceSC.com).

The employer should check the appropriate box on the enrollment form — either original enrollment or enrollment change with corresponding reason — and fill in the effective date. If there is an enrollment change, the employer must list the qualifying event. The employee should complete the rest of the form.

The enrollment form also asks about other health benefits the employee or family member(s) may have.

**We will not make any benefit payments if this information is incomplete.** Once the enrollment form is complete, the employee should sign and date it. Then send it to us at:

BlueChoice HealthPlan  
Attn: Membership, AX-425  
P.O. Box 6170  
Columbia, SC 29260

If you need any materials or extra information about our products, we have an agent help line. Contact Marketing Support toll free at 866-280-0766, or in Columbia at 382-5976.

## 3.2 Changes

### Changes in Employment Status

- **Termination of Employment** — A member's coverage ends at the end of the month after termination. It might be earlier, however, based on that group's policy. Retroactive deletions are acceptable. **But this is only if we receive them within 31 days of the member's coverage termination, and if the member had no benefit payments during those 31 days.** If we paid benefits during that period, premiums are due and payable through the end of the month in which we provided benefits. See Sections 3.9 and 3.10 for coverage continuation options.
- **Layoffs/Leaves of Absence** — Members may be able to continue their coverage on a group/individual basis.

### Changes in Family Status

Please notify us of any changes in a family's status within 31 days of the qualifying event. Please use the Application and Change form to add or terminate a family member. Please remember, the form must contain the:

- Employee's name
- Employee's address.
- Employee's Social Security Number.
- Requested effective date.

The employee or group leader should check the "Cancel Dependents" box (section A). He or she should also indicate the reason for termination (divorce, death, other).

The employee should list each dependent he or she wishes to disenroll. Have the employee do this in the same section of the enrollment form as the original (section C). The employee should include the dependent's full name, gender and date of birth.

## 3.3 Qualifying Events

We recognize these qualifying events as reasons to change status:

- Birth
- Marriage or divorce
- Death
- Legal adoption
- Addition of stepchildren or foster children
- Permanent legal custody
- Reinstatement of civilian status
- Spouse's loss or gain of employment and insurance coverage, with these requirements:

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1. Spouse's employer sends written notification to us of the spouse's loss or gain of employment or insurance.
2. The spouse's gain of employment and insurance coverage allows the member to delete only the spouse from current BlueChoice HealthPlan coverage, not dependents (with employer's permission).
3. The spouse's loss of employment and insurance coverage allows the member to add the spouse and other eligible family members the spouse previously covered.

Please use the Application and Change form to notify us of any change in employment status or family situation that may affect coverage. Our Membership department must receive this form within 31 days of the qualifying event. Once we receive premiums, coverage will take effect on the date of the event. **We do not accept additions, deletions or changes outside this 31-day period.**




### 3.4 ID Card and Benefit Information

Once we have processed the enrollment form, we will send the new member an ID card and a Welcome to BlueChoice HealthPlan letter.

- **BlueChoice HealthPlan ID card** – The member should verify all information on the front of the card. The member should carefully read the information on the back. The member should carry the card at all times and present it whenever he or she receives medical services.
- **Welcome Letter** – We provide information on [www.BlueChoiceSC.com](http://www.BlueChoiceSC.com) to help members understand their benefits. The information includes:
  - ◆ **Certificate of Coverage** — This is information about the group's contract with us. It reflects the benefits and limitations of the plan.
  - ◆ **Schedule of Benefits** — This provides a brief explanation of the member's copayment and cost-sharing responsibility for each type of medical service. It will also include information on:
    - Any supplemental riders for durable medical equipment.
    - Prescription drugs.
    - Dental or vision care the group has purchased.
  - ◆ **Member Guide** — This guide has information that reflects the benefits, limitations and responsibilities of both the member and the plan.

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Sample CarolinaADVANTAGE ID Card

	
JOHN DOE	
ZCL00000000	
RxBIN	004336
PCN	CHC
	

BC96-1 FI CA Rx

Here is an explanation of each field that **may** appear on the member’s ID card, depending on the product offered:

- **ID** — The member’s BlueChoice HealthPlan identification number.
- **Suitcase** —Indicates the member has BlueCard coverage. If the member is traveling and needs medical care, the office staff will recognize this suitcase and file the claim.

### 3.5 Health Insurance Portability and Accountability Act (HIPAA)

To comply with HIPAA, when an employee terminates coverage or COBRA terminates, we will generate a **Certificate of Creditable Coverage** (Appendix K), which will be mailed to the employee's current address on file. We may also generate a copy at the member's request. We also offer additional services to assist you in maintaining compliance with the HIPAA law. These services include:

- **Determination of Prior Coverage** — Analysis of evidence of prior coverage by membership services
- **Pre-existing Condition Exclusion Notice Letter (Appendix L)** — Calculates remaining pre-existing condition clause and informs member of end date for pre-existing condition clause
- **Reconsideration of Pre-existing Condition Exclusion** — If a member submits subsequent evidence of prior coverage

It is important that you inform us to indicate your preference for any of these services.

### 3.6 Termination of Group Contract

We may non-renew or discontinue our offer of health care coverage in connection with a group health plan based on one or more of these:

1. **Non-payment of Premiums** — The employer has failed to pay prepaid fees or contributions according to the terms of the contract. Or, we have not received timely prepaid fees. The contract, and all certificates issued thereunder, shall automatically terminate without notice on the 31<sup>st</sup> day following a prepaid fee due date, unless we receive the full prepaid fee at our home office no later than the 30<sup>th</sup> day after the due date. The contract shall continue in force during that 31-day period. The employer is liable for the full, prepaid fee for that period.
2. **Fraud** — The employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the contract. Or, with respect to coverage of a member, fraud or intentional misrepresentation by the member or the member's representative. If the fraud or intentional misrepresentation is made by a person with respect to any person's prior health condition, we have the right also to deny coverage to that person or to impose as a condition of continued coverage the exclusion of the condition misrepresented.
3. **Violation of Participation or Contribution Rules** — The employer has failed to comply with a material plan provision relating to employer contribution or group participation rules.
4. **Termination of Coverage**
  - A. We may discontinue offering this particular type of coverage provided we:
    1. Provide notice to each employer that provides the coverage and the covered members of the discontinuation at least 90 days before coverage ends.
    2. Offer to each employer providing the coverage the option to purchase any other health insurance coverage we currently offer to a group health plan.

## BlueChoice HealthPlan

3. Act uniformly, without regard to the claims experience of those employers or any health status-related factor relating to any covered member or new member who may become eligible for coverage.
- B. We may elect to discontinue offering all health insurance coverage in this state if we:
  1. Provide notice to the Director of Insurance and to each employer and covered member of the discontinuation at least 180 days before coverage ends.
  2. Discontinue all health insurance coverage we issue or deliver in this state in such market and do not renew coverage under the health insurance coverage in the market.

We may not issue any health coverage in the market in the state during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

5. **Movement Outside the Service Area** — If there is no longer a minimum of 25 percent of the enrollees in connection with this plan who live, reside or work in our local service area or in the area for which we are authorized to do business.

### 3.7 Termination of Employee Contract

When an employee becomes ineligible for the group's health coverage, please have the group administrator complete an Application and Change form to terminate the member's contract with us. We must receive this form within 31 days of the qualifying event, as we do not accept retroactive disenrollment. The Application and Change form should indicate the effective date of change, along with the reason for change (termination, death, conversion or COBRA applicant). If the subscriber is not available to sign the form, the group leader or personnel representative may sign.

Please note that if we paid benefits after the requested termination date, prepaid fees are due and payable through the month in which we provided benefits.

### 3.8 COBRA

A member whose coverage would otherwise end under the contract may be eligible to elect continuation of coverage according to the federal law under COBRA (Consolidated Omnibus Budget Reconciliation Act) or convert to an individual policy. We will require the employer to submit a completed and signed Application and Change form.

Members who continue their coverage through COBRA stay with the same benefit plan in which they previously enrolled. COBRA participants generally have the same options as active employees. Please refer to the federal COBRA regulations governing election periods, eligibility and notification requirements.

### **3.9 Conversion to Non-group Policy**

Members without COBRA options who continue to reside in our service area may be able to convert to an individual policy. Employees may not have any lapse in coverage or have been terminated for non-payment of premiums prior to conversion. This conversion policy is available until the member becomes eligible under another group health plan or elects to cancel this coverage. A summary of benefits and copayments schedule for this benefit plan is available upon request. Premium rates and benefits are subject to change.

To continue benefits, we must receive the Application and Change form indicating conversion within 31 days of the loss of coverage. We also require that the member submit payment for the first quarterly premium with the Application and Change form within 31 days of the loss of coverage.

## **SECTION 4**

### **Claims and Member Services**

4.1 Member Billing

4.2 Explanation of Benefits

4.3 Coordination of Benefits

4.4 Medicare Coordination

4.5 Subrogation

4.6 Appeal Procedures

4.7 Member Services

4.8 Automated Telephone System

4.9 Website

4.10 BlueCard and Urgent Care

4.11 Health Management Programs — Great Expectations  
*for health.*

## Section 4 Claims and Member Services

### 4.1 Member Billing

Our participating physicians, hospitals and other providers bill us directly. A member makes copayments at the time of service and should not receive any bills for covered services. If a member receives a bill for anything other than copayments, deductibles or coinsurance, he or she should submit the bill to Member Services. We will review and pay the claim if it is a covered benefit. We follow the same procedure for any out-of-area emergency claims.

### 4.2 Explanation of Benefits

After a member visits a facility or specialist and we process the claim, the member will receive an Explanation of Benefits (EOB) from us (Appendix N). The EOB will show a breakdown of the charges the member is responsible for paying.

### 4.3 Coordination of Benefits

We work hard to control the rising costs of medical care. One way we do this is through Coordination of Benefits (COB). Sometimes, a member is covered under more than one group health plan. We refer to the different plans as either primary or secondary. The primary health plan is responsible for paying for the medical claim first. The secondary plan pays only after the primary has paid.

COB is a method of calculating payments between the primary and secondary plans so that no more than the actual charges are paid. Without COB, claims would be overpaid and insurance rates would rise. COB allows us to give the member all of the coverage he or she is entitled to without exceeding the actual cost of the care the member receives.

If a member is covered by more than one health plan, the Explanation of Benefits (EOB) the member receives following the service breaks down the payment responsibilities between the member and his or her health plans. If we are the secondary plan, we must receive an EOB from the primary plan before we can pay the claim.

Dependent children, whom both parents cover under each of their health plans, fall under COB. The children's primary plan is that of the parent whose birthday occurs first in the calendar year. The other parent's plan is secondary.

Please note: If we are the member's secondary health plan, the member must:

- Follow the policies and procedures (authorization, referral, etc.) of his or her primary health plan.
- See a participating provider.
- Follow all authorization rules.

### 4.4 Medicare Coordination

When we cover active employees with Medicare:

- For employers with 20 or fewer employees, Medicare is the primary carrier.
- For employers with more than 20 employees, we are the primary carrier. We are also the primary carrier for retired employees with Medicare coverage who remain on the active group policy. We will coordinate benefits with Medicare.

## **4.5 Subrogation**

We have the right of subrogation. This means we may recover from a liable third party the amount we paid toward the cost of a member's health care for injuries or illnesses for which the other party was responsible. If the member received a settlement (as a result of an accident or legal claim), we may seek recovery from the member or the third party.

## **4.6 Appeal Procedures**

To appeal a decision regarding the provision of benefits under the member's contract, the member can contact one of our representatives. The member should state the issue he or she needs reviewed and attach pertinent medical records or other information in support of the appeal. The member also can request a description of any pertinent records that we reviewed in making the original decision to deny the claim in whole or in part. If the complaint involves a representative of BlueChoice HealthPlan, the member should address the request to the chief operating officer of BlueChoice HealthPlan. If a complaint is related to the quality of care a member received, we consider it a grievance. The member should submit a description of the problem in writing to a BlueChoice HealthPlan representative.

Our representative will notify the member of receipt of the complaint or appeal and will arrange for a review by an appropriate representative of BlueChoice HealthPlan. We will resolve a complaint or appeal within 30 days from the date we received it. We may extend this period if there is a delay in getting the documents or records necessary for the resolution of the matter.

If the problem is an appeal of the denial of an authorization, the member can request that the individual who reviews the request be a person who did not make the initial decision of denial. The member can request that the reviewer be a provider licensed in the same specialty as the attending medical provider. If the member believes the determination to deny authorization warrants immediate appeal, the member can request an expedited appeal. For an expedited appeal, we will make a decision and notify the member of the decision within two business days of our receipt of all information necessary to complete the appeal. If the result of the expedited appeal does not resolve the difference in opinion, the member can resubmit the appeal through the standard appeal process.

Members must submit all claims, questions, grievances or appeals within six months after the last date of services rendered or the date we denied the claim for services. After the expiration of this period, we will consider disposition of the claim final. Members must ask any questions or make any appeals they have concerning authorizations to us within six months from the date we approved or denied their authorizations, or we will consider the decision final.

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### **External Review by an Independent Review Organization**

The Health Carrier External Review Act, a state law, allows members to ask for an external review in some cases where we deny payment for a claim. After following our standard appeals process, a member may be entitled to an additional review of the appeal at our expense. To qualify, the member's case must meet all of these conditions:

- The member appealed initially because we denied payment, either entirely or in part, of a covered service.
- The payment was more than \$500.
- We denied, reduced or terminated the requested service or payment because:
  1. It did not meet our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and/or
  2. It is experimental or investigational and involves a condition that is life-threatening or seriously disabling.

After we complete all internal appeals, we will notify the member in writing of the right to request an external review. The member should file a request for review within 60 days of receiving that notice.

The member must authorize the release of any medical records that may need to be reviewed for the purpose of reaching a decision during the external review. If a member needs assistance during the external review process, he or she has the right to contact the South Carolina Department of Insurance. The member can contact the director of the South Carolina Department of Insurance or his or her designee at:

South Carolina Department of Insurance  
P.O. Box 100105  
Columbia, SC 29202-3105  
800-768-3467

Within five business days of the request for an external review, we must respond by either:

1. Assigning the review and forwarding records we used in making the decision to an independent review organization.
2. Telling the member in writing that the situation does not meet the requirements for an external review and the reasons for this decision.

The independent review organization will take action on the request for review within 45 days after it receives the request. Expedited reviews are available if the member's physician certifies that the member has a serious medical condition, meaning one that requires immediate medical attention to avoid serious impairment to bodily functions, serious harm to an organ or body part, or would place the member's health in serious jeopardy. The member also can receive an expedited review if the denial involves an emergency admission or emergency care, the member has not been discharged from a facility after receiving that care or the member will be held financially responsible.

## 4.7 Member Services

Our member advocates are available to answer members' questions and help them understand their benefits such as:

- Questions about claims or bills
- Benefits clarification
- Eligibility inquiries
- Coordination of other health coverage or benefits
- Out-of-area care and authorization
- Emergency room services
- And more — just call us and ask!

Phone: 800-868-2528

Marketing Support: 866-280-0766 (In Columbia, call 382-5976)

Hours: Monday – Friday (except holidays), 8:30 a.m. to 8:30 p.m. (Eastern Time)

[www.BlueChoiceSC.com](http://www.BlueChoiceSC.com)

## 4.8 Automated Telephone System

We have an automated telephone system available to members at 800-868-2528. When the automated operator answers, the member can follow the prompts and enter his or her BlueChoice HealthPlan member ID number. With this service, the member can:

- Get referral information
- Find claims status information
- Get eligibility and benefits information
- Get away-from-home care and guest membership information
- Select or change his or her primary care physician by using the automated attendant
- Request handbooks, directions and member literature
- Get emergency services information
- Speak with a Member Services representative

## 4.9 Website

Our website is your online resource for health care coverage information. There is information about our health plans and wellness programs. You can also download forms or search our network directories. We have a section just for agents where you can access Accel-A-Rate and modify your agent profile. Just go to [www.BlueChoiceSC.com](http://www.BlueChoiceSC.com) and select the Agents section.

Group administrators and members can also use the website to find answers to their questions or to get forms. Using My Health Toolkit<sup>®</sup>, a member can check on his or her claim and print a copy of his or her Explanation of Benefits.

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My Health Toolkit and its secure email capability provide safe and convenient information for our members. With My Health Toolkit, the member has access to benefit information at his or her convenience. And when a member emails questions or requests to us, he or she has a convenient record of the inquiry and our response.

### 4.10 BlueCard

BlueCard gives members access to their health care benefits, regardless of where they live or travel, through a network of participating physicians and hospitals. Within the U.S., the member should:

- Always carry his or her current BlueChoice HealthPlan ID card for easy reference and access to service.
- In an emergency, go directly to the nearest hospital.
- Call BlueCard Access at 800-810-BLUE (2583) or check the Doctor and Hospital Finder at [www.BlueCard.com](http://www.BlueCard.com) to find nearby doctors and hospitals.
- Call us for pre-certification or prior authorization, if necessary. The member should refer to the phone number on the back of his or her ID card.
- Present his or her ID card at the participating doctor's office or hospital. The doctor will recognize the suitcase logo, which gives the member access to the traditional or PPO networks, depending upon the product offered.
- Not have to complete any claim forms or pay up front for medical services other than the usual out-of-pocket expenses (deductibles, copayments, coinsurance and non-covered services).

Around the world, the member should:

- Always carry his or her ID card when traveling or living outside the U.S.
- Follow the simple process as in the U.S., with these exceptions:
  - o In most cases, the member won't need to pay up front for inpatient care at BlueCard worldwide hospitals. The member is responsible for the usual out-of-pocket expenses (non-covered services, deductibles, copayments and coinsurance). The hospital should submit the member's claim.
  - o The member should pay the doctor or hospital for inpatient care, outpatient hospital care and other medical services at non-BlueCard worldwide hospitals. Complete an international claim form and send it to BlueCard Worldwide Service Center. Members can find the claim form at [www.BlueCard.com](http://www.BlueCard.com).

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## Urgent Care

Whether a member is away from home with an upset stomach or his or her child catches the flu, just have the member call the BlueCard program at 800-810-2583. A representative will find three network participants located in that travel area. The member is responsible for scheduling an appointment.

Remember, urgent care is for any unexpected illness or injury that occurs while traveling that requires treatment before the member returns home. In a life-threatening emergency, the member should call 911 or go to a hospital immediately and notify us according to the group plan's instructions.

Please note that services are not available in all areas.

## 4.11 Health Management Programs – *Great Expectations for health*

We are more than just a health benefits plan. We have programs targeting many specific health issues. We designed these programs to help members practice prevention, make healthy lifestyle choices and engage in self-care behaviors that may improve their health. We offer these programs only to our members. The programs are either free of charge or have a small, one-time fee. Here we have included a short description of each program. For more information, please call our Health and Disease Management department at 800-327-3183, ext. 25541. Or, visit our website at [www.BlueChoiceSC.com](http://www.BlueChoiceSC.com) and go to the Great Expectations for Health Programs section under Health & Wellness.

**Great Expectations Asthma** is an educational program for members with asthma. We automatically enroll all members who have asthma in the program at **no charge**.

The program consists of:

- An asthma manual sent upon enrollment. This includes information about asthma medications, asthma triggers and peak flow monitoring.
- An annual program calendar, newsletters, and seasonal allergy and asthma information.
- A free peak flow meter to members with chronic episodes.
- Telephone counseling sessions with a registered respiratory therapist.
- Home health education visits to members with moderate- to high-risk asthma who need additional help managing and controlling their condition.
- Web resources.

**Great Expectations Back Care** helps members with back pain that may be keeping them from completing daily tasks, being active or just fully enjoying life. This program provides educational tools and support to help members take care of their backs.

To manage back pain, members are sent a “Back to Basics” packet, which includes:

- Educational materials to help in understanding back pain.
- Strengthening and stretching exercises to help prevent future problems.
- A Back Care Survey to take to the doctor.
- Additional resources to contact for further information and support.

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**Great Expectations *Childhood Obesity*** helps families address the problem of childhood obesity. We automatically enroll members ages 2 to 17 who have a diagnosis of overweight or obesity in the program at **no charge**.

The program consists of:

- Educational materials about healthy eating and increasing activity.
- Age-appropriate interactive tools.
- A visit with a registered dietitian, at no charge to the member.
- Incentives for children who complete their registered dietitian visits.

The **Great Expectations *Children's Health*** program reminds parents of the importance of well-child checkups and immunizations for their children. We automatically enroll all children ages 12 and under at **no charge**.

The program consists of:

- Educational materials for parents of newborn babies. This includes information on childhood diseases, the immunizations available to prevent these diseases and the possible side effects of immunizations.
- Reminder cards at 2, 4, 6, 15 and 18 months and 12 years of age. The cards list the immunizations needed at each age and encourage the parents to keep up with well-baby/child visits.
- Reminder letters to encourage well-child visits.
- Automated phone messages to remind parents about booster immunizations for children and adolescents.
- Web resources.

**Great Expectations *COPD*** is an educational program for members with chronic obstructive pulmonary disease (COPD). We enroll all members who have COPD at **no charge**.

The program consists of:

- A COPD manual sent upon enrollment. This includes information about COPD medications, appropriate nutrition and exercise, and prevention and management of COPD exacerbations.
- Information about BlueChoice HealthPlan's coverage of COPD medicine and supplies.
- COPD newsletters and seasonal information.
- Telephone counseling sessions with a respiratory therapist.
- Home health educational visits by a respiratory therapist for members who need additional help in controlling their COPD.

The **Great Expectations *Depression*** program is for members who may have depression or have been diagnosed with depression and are newly started on an antidepressant medication. The program educates members about depression-related issues. This includes the importance of following their physicians' recommendations for care. We automatically enroll members in the program if they have a recent depression diagnosis. We also identify members through a screening assessment completed through our disease management programs.

The program consists of:

- A 20-minute phone assessment with a behavioral health specialist.

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- Follow-up phone calls from behavioral health specialists regarding depression treatment and compliance with medications, as indicated.
- Education and materials about depression, antidepressant medications and the need for physician follow-up.
- Assessment results sent to physicians, if the member consents to this.
- Referral for behavioral health counseling, when requested, by the member.
- Web resources.

**Great Expectations *Diabetes*** is an educational program for members with diabetes. We automatically enroll all members who have diabetes at **no charge**.

The program consists of:

- Educational materials about diet, exercise, medication, blood sugar monitoring and complications.
- Information about our coverage of diabetic medicine and supplies.
- Annual program calendar and newsletters about diabetes and related issues.
- Telephone counseling sessions with diabetes health specialists, which include a registered dietitian, certified diabetes educator and diabetes nurses.
- Diabetes education, available for any member, without an authorization and at no expense to the member. It must be provided by an approved diabetes education center.
- Free glucose monitors. Supplies such as test strips, lancets and syringes are covered as part of pharmacy benefits with a physician prescription. To request a free glucose monitor, call 800-327-3183, ext. 25450.
- Self-referral authorizations for eye exams and a wellness voucher for an annual diabetes checkup, sent to all members, allowing them to access these services at no charge.
- Web resources.

The **Great Expectations *Healthy Women*** program educates women, ages 20 and above, about the early detection of breast and cervical cancer, the management of menopause, the prevention of osteoporosis and heart disease, and other important women's health issues. We automatically enroll all female members automatically at **no charge**.

The program consists of:

- Educational materials for new members. This includes information about the early detection of breast and cervical cancer, the management of menopause and other important health topics for women.
- Postcard and phone call reminders to women to encourage them to get their preventive screenings.
- Reminders for physicians concerning their patients that are due for yearly well-woman exams and screenings. This includes an automatic referral program for women in need of mammograms and Pap smears.
- Promotion of mobile mammography through local hospitals for employer groups.
- Wallet cards for members to track their preventive health screenings including information on how often to receive them.
- Web resources.

**Great Expectations *Heart Disease*** is an educational program for members who have been diagnosed with coronary artery disease (CAD). The program educates members about lifestyle

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behaviors they can change to lower their risk of complications. It also educates members about the importance of taking prescribed medications and working closely with their physicians. We automatically enroll all members who have heart disease at **no charge**.

The program consists of:

- Educational materials about cholesterol, high blood pressure, smoking cessation, diet, medication management, exercise and early recognition of heart-related health problems.
- Physician and member reminders to ensure LDL cholesterol lab tests are conducted annually and LDL cholesterol levels are within recommended ranges.
- Telephone counseling sessions with a cardiac nurse for members who are high risk.
- Information about our coverage of cardiac-related conditions, medications and related services, such as cardiac rehabilitation.

**Great Expectations Heart Failure** is an educational program for members who have heart failure. We automatically enroll members identified with heart failure at **no charge**, and physicians can also refer patients. The goal of the program is to educate members about appropriate self-care strategies to minimize exacerbation of their condition.

The program consists of:

- A heart failure educational manual.
- Member reminders and information about managing high cholesterol and high blood pressure.
- Telephone counseling sessions with a cardiac nurse for members who are high risk.
- Information about our coverage of cardiac-related conditions, medications and related services.
- Web resources.

The **Great Expectations Maternity** program helps members take steps toward a healthier pregnancy with educational materials and ongoing support and monitoring by our Great Expectations staff. We automatically enroll a member in the program at **no charge** when her primary care physician or obstetrician sends in a maternity authorization form.

The program consists of:

- A maternity packet, including a detailed health assessment. When a member completes and returns the risk assessment, she receives her choice of either a pregnancy or child care book.
- Telephone counseling for members, based on their risk level. Medium- and high-risk members receive ongoing monitoring and phone calls from a nurse case manager.
- Additional educational materials, as needed.
- Referrals to external prenatal programs such as Sidelines of SC, WIC and other groups that may provide further assistance (financial, emotional, etc.).
- A postpartum packet to include important reminders for follow-up care and resources for the new mother and her baby.
- Web resources.

**Great Expectations Men's Health** is an educational program for men. We designed the program to remind men, ages 40 and older, of the importance of routine health screenings.

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The program consists of:

- Educational materials sent to newly enrolled members. This includes information on recommended screenings, a wallet card to track screenings and other important health issues for men.
- Reminder letters sent to men who have not had a physician visit in the last year. The letters outline age-appropriate screenings and encourage them to make an appointment for a physical.
- Web resources.

**Great Expectations *Migraine*** is a program for members who suffer from severe, recurrent headaches. We provide information to members and encourage them to seek help from their personal physicians to guide their headache management. We enroll members at no charge when they meet our criteria for frequent and severe headaches.

The program consists of:

- Educational materials that help the member assess the severity and type of headaches they have.
- A headache diary, which members can use to track their headache patterns to determine possible triggers, in addition to several educational handouts on migraine-related topics.
- Assisting the member's physician by providing up-to-date and actionable information to improve continuity of care and treatment for that member's headaches.

We designed the **Great Expectations *Quit Smoking*** program to help members quit smoking. Members get a self-paced comprehensive kit of information, along with access to a quit smoking coach for support and guidance. There is a \$15 fee for the program. The fee is reduced to \$5 for members participating in one of our other Great Expectations programs. Members may self-refer or be referred through their physicians.

The program consists of:

- A kit which comes complete with a CD to guide members through the program and provide relaxation exercises. The kit also includes educational booklets with a structured process and tips for quitting, log sheets to track progress, and a nicotine dependency quiz. Members can review the quiz with their physicians as they consider quit smoking medications.
- Unlimited inbound phone calls to a trained quit smoking coach who will lend support and guide interested members through the program and the quitting process.
- Access to our staff who will clarify member benefits for pharmaceutical interventions for smoking cessation, now covered under the pharmacy benefit for most members.
- Web resources.

The **Great Expectations *Weight Management*** program helps members lose weight. Members get a comprehensive kit of materials and access to a weight loss coach. The program fee is \$15. The fee is reduced to \$5 for members participating in one of our other Great Expectations programs.

The program consists of:

- A kit of materials containing a workbook to guide members through the 10-week self-paced program, a CD of relaxation exercises, a resistance exercise band, menus and recipes for the whole family, and a record book to keep track of food intake.

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- Unlimited inbound calling to a weight loss coach who will help support and guide members through the weight loss process.
- Web resources.

**SECTION 5**  
**Agent Services**

5.1 Agent of Record Procedures

5.2 Commissions

### 5.1 Agent of Record Procedures

Since we value our relationships with agents who write business with us, it is important we establish guidelines for agent status changes within groups.

#### **Large Group (51+)**

Agent of Record (AOR) letters supercede all other requests since they determine who gets paid commissions on groups of 51+. We will honor any AOR request provided that we receive a letter, on company letterhead, that is signed by an official of the company. The change will be effective as indicated in the letter. We will pay commissions on the following month's commission schedule. If we receive the AOR after the 15<sup>th</sup> of the month, the change will be effective the first of the following month.

#### **Small Group (2–50)**

We will honor AOR changes after the first policy year is complete. Once a small group account has been on the books for one full policy year, we will honor these requests at the time the requests are made. We will pay commissions and agency overrides on the following month's commission schedule.

**We must receive all AOR requests in writing on company letterhead. They are subject to approval before we grant the requests.**

**5.2 Commissions**



**SCHEDULE OF STANDARD AGENT COMMISSIONS**

**Base Commissions (2–50 lives)**

**Health New Sales**

For period beginning January 1, 2007: **\$23 per contract per month**

**Health Renewals**

For period beginning January 1, 2007: **\$20 per contract per month**

Dental New Sales and Renewals:

Paid according to this schedule:

<u>Premium Amount</u>	<u>Commission Percentage</u>
First \$10,000	8%
Next \$15,000	6%
Next \$25,000	4%
Next \$25,000	3%
More Than \$75,000	2%

**Life New Sales and Renewals**

Per current standard Companion Life Insurance Agency Schedule

	<b>Percent of Premiums</b>	
	<b>First Year</b>	<b>Renewal</b>
<b>I. True Group Long Term Disability (LTD), 13 Plus</b>		
First \$5,000 of Annual Premium	15.0%	15.0%
Next \$10,000 of Annual Premium	10.0	10.0
Next \$10,000 of Annual Premium	8.0	8.0
Next \$20,000 of Annual Premium	5.0	5.0
All Annual Premiums in excess of \$45,000	2.5	2.5
<b>II. True Group Life, AD&amp;D &amp; Short Term Disability (STD), 13 Plus</b>		
First \$5,000 of Annual Premium	15.0%	15.0%
Next \$10,000 of Annual Premium	10.0	10.0
Next \$10,000 of Annual Premium	8.0	8.0
Next \$20,000 of Annual Premium	5.0	5.0
All Annual Premiums in Excess of \$45,000	2.5	2.5
<b>III. Small Group Life, STD and LTD, 2–12 employees</b>	15.0%	15.0%
<b>IV. Voluntary Life, STD and LTD</b>	15.0%	15.0%
<b>V. Voluntary Dental</b>	10.0%	10.0%

**Base Commissions Large Group (51+ lives)**

The maximum standard commission of 5 percent is paid on first year groups with 51+ lives. This percentage can vary on a case-by-case basis. Commissions can and will vary upon renewal.

*These commission rates are subject to change at the discretion of BlueChoice HealthPlan management.*