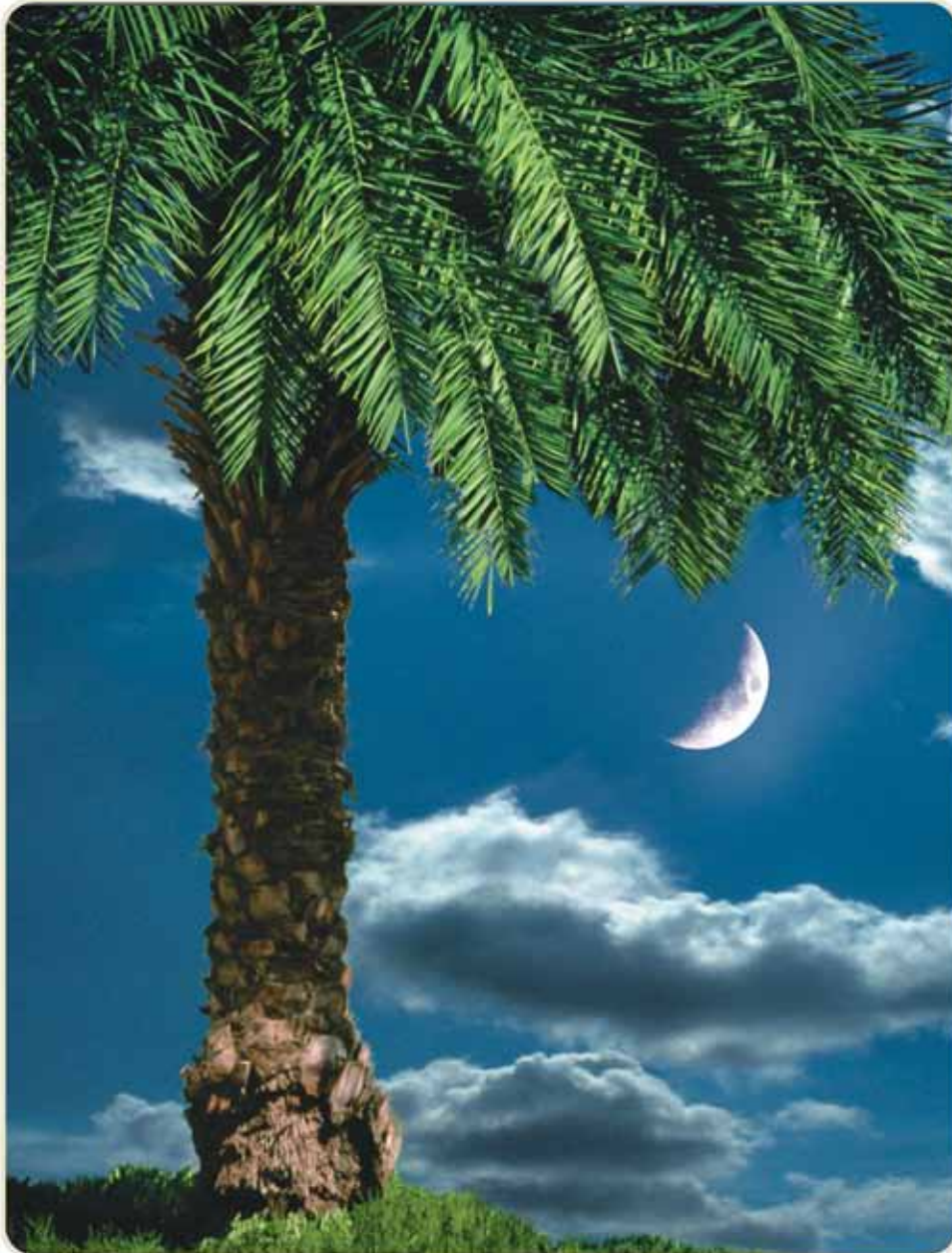


POINT of SERVICE

How Your Benefits Work

Your Guide to BlueChoice HealthPlan Services



www.BlueChoiceSC.com



**BlueChoice[®]
HealthPlan**

South Carolina

An independent licensee of the
Blue Cross and Blue Shield Association



BlueCard® Services

When You Travel

If you are traveling outside of the BlueChoice HealthPlan network service area and need treatment, we will cover initial treatment of emergency and urgent care. Please call 1-800-810-BLUE (2583) and ask for a referral to the nearest physician or urgent care center. Refer to the Emergency and Urgent Care section on page 4 for more information.

Within the U.S.

- Always carry your current BlueChoice HealthPlan ID card for easy reference and access to service.
- In an emergency, go directly to the nearest hospital.
- To find nearby doctors and hospitals, call BlueCard Access at 1-800-810-BLUE (2583) or visit www.BlueCard.com and click on “Find a Doctor or Hospital.”
- Call BlueChoice HealthPlan for pre-certification or prior authorization, if necessary. Refer to the phone number on the back of your card.
- When you arrive at the participating doctor’s office or hospital, simply present your ID card. If you are a BlueChoice HealthPlan member, the doctor will recognize the suitcase logo on the card, which ensures that you have access to the traditional networks.
- You should not have to complete any claims 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

- Always carry your BlueChoice HealthPlan ID card when you travel or live outside the U.S.
- Follow the same simple process as in the U.S., with the following exceptions:
 - In most cases, you should not need to pay up front for inpatient care at BlueCard® Worldwide hospitals. You are responsible for the usual out-of-pocket expenses (non-covered services, deductible, copayment and coinsurance). The hospital should submit your claim.
 - You 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. The claim form can be found at www.bcbs.com/bluecardworldwide.

Away From Home Care

Anytime you or one of your family members will be away for at least 90 days, you can become a guest member of an affiliated Blue Cross and Blue Shield health plan near your destination. Just call BlueChoice HealthPlan and explain your situation. Students and long-term travelers are two groups that can benefit from Away from Home Care. You can call the number on the back of your ID card, or visit www.BlueChoiceSC.com for more information.

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Welcome to BlueChoice HealthPlan. We are pleased that you have selected us to be your health plan. This guide will help you take full advantage of your health plan benefits. Please take a moment to look through this information, and keep it handy for future reference.

Remember, we're here to help you. If you need to contact Member Services for any reason, you can do so through any of the following methods:

Visit our Web site:

www.BlueChoiceSC.com

Write to us:

BlueChoice HealthPlan
Member Services
P.O. Box 6170
Columbia, SC 29260-6170

Or call Monday through Friday between 8:30 a.m. and 8:30 p.m.:

(803) 786-8476 In Columbia
1-800-868-2528 Outside of Columbia

Again, thank you for choosing BlueChoice HealthPlan. We look forward to serving you.

Learning About Your Health Plan

Being well informed is one of the best ways to make our services work for you. The information in this guide will help you understand your health plan coverage and how it works *before* you need to go to the doctor.

What We Pay For

- In order to receive payment from us, a service must be medically necessary and be listed as a covered service in your *Schedule of Benefits* or *Certificate of Coverage*. Payment is provided for covered services you receive while you are enrolled as a member of BlueChoice HealthPlan.
- Your health plan provides benefits for both referred care and self-referred care. Referred Care is medical care provided by, or coordinated through, your primary care physician. When you need to see another health care professional participating in the BlueChoice HealthPlan network, your primary care physician will contact us for approval. We will pay at a higher benefit level for this referred care.
- Self-referred care is medical care you receive without contacting BlueChoice HealthPlan or your primary care physician for approval. While your

plan does allow you to receive care without prior approval, please be aware that we pay at a lower benefit level for these services. Also, self-referred care must be medically necessary and listed as a covered service in your *Schedule of Benefits* or *Certificate of Coverage*.

- Please remember, BlueChoice HealthPlan must approve all inpatient admissions to the hospital other than emergency admissions. You must notify us of non-emergency inpatient admissions at least two business days before the admission date. If you are uncertain if we have approved a service, please contact Member Services.
- The benefits provided by your plan may be different from the benefits of another plan. To see exactly what services are covered under your plan, please check your *Schedule of Benefits* or *Certificate of Coverage*.

What We Do Not Pay For

- Please refer to your *Certificate of Coverage* for a list of the services not covered under your plan. **Services not covered are called “exclusions,” while services with restrictions are called “limitations.”** If you receive a service that falls under one of these categories, you will be responsible for payment of the resulting charges.

Physician Information

Your Primary Care Physician

An important part of your health care experience is building a relationship with a personal primary care physician who will coordinate and oversee your medical care. We encourage you and each member of your family to select a primary care physician early in your membership with BlueChoice HealthPlan.

What they do – BlueChoice HealthPlan’s participating primary care physicians have accepted the responsibility of providing or arranging for your health care needs. Because they are trained to have a broad range of medical expertise, they are in the best position to refer you to the appropriate specialists, admit you to the hospital if needed and help coordinate any healthcare services you may need. Your primary care physician will also file claims for you and ask you to pay only your copayment, deductible or coinsurance amounts for covered services. You may receive a second medical opinion from another participating BlueChoice HealthPlan physician upon request.

Availability – All primary care physicians are required to have 24-hour telephone service and a physician on call if they are unavailable. To obtain services, just call your physician’s office. Even if you get sick or injured after your doctor’s normal office hours, you should still call your primary care physician. By establishing a relationship with your primary care physician, you have the security of knowing a medical professional is ready to help you 24 hours a day, seven days a week.

Choosing a primary care physician – You may choose your primary care physician from BlueChoice HealthPlan’s list of participating physicians. The list is available on our Web site at www.BlueChoiceSC.com or by calling Member Services. You and your family may all choose the same physician, or each family member may select his or her own. If you are not currently a patient of the physician you choose, please make sure that physician is accepting new patients.

Changing your primary care physician – If you’d like to change your primary care physician, simply visit our Web site or contact Member Services. Again, please be sure to select a physician from our list of participating primary care physicians and make sure that he or she is accepting new patients. Your change will be effective the same day we receive your request.

If you would like information about a physician, including his or her qualifications and title, please contact Member Services.

When You Need to See a Specialist

If you need services that your primary care physician cannot provide, he or she may recommend that you see a participating specialist. If your primary care physician refers you to a specialist, you’ll get an authorization form for that office visit. You will then have referred care benefits for approved services that are included in your plan. Remember, these pay at a higher benefit level than self-referred benefits.

You may see a specialist without first receiving approval from your primary care physician and BlueChoice HealthPlan. Then self-referred care benefits will be available for services included in your plan. This is the case even if you were a patient of the specialist before you became a BlueChoice HealthPlan member.

Other Health Care Providers

Other participating health care providers include hospitals, skilled nursing facilities, home health agencies, hospices and other providers of medical services and supplies who agree to be a part of the BlueChoice HealthPlan network. To obtain benefits for referred care services from any of these providers, you’ll need to get a referral from your primary care physician or authorized specialist. If you do not get a referral, then self-referred care benefits will be available for services included in your plan. Please see your *Schedule of Benefits* for a complete list of your covered benefits.

Inpatient Admissions

To receive referred care benefit coverage for an inpatient admission, you must have authorization from BlueChoice HealthPlan and your primary care physician (or participating specialist). Your physician will coordinate this authorization process.

To receive self-referred care benefit coverage for an inpatient admission, you must contact BlueChoice HealthPlan before your admission date. If you do not follow the authorization guidelines, no benefits will be provided for these services.

Remember, in order to receive referred care benefits, make sure you get approval for services before receiving them. If you don't, inpatient admissions will be denied and other services will be covered at the lower self-referred care benefit level. For self-referred care, if you go to a non-participating provider or hospital, benefits are provided for allowable charges.

Gynecologist (GYN)

BlueChoice HealthPlan provides benefits for female members to get regular, preventive care. If you go to a gynecologist who is part of the BlueChoice HealthPlan network of physicians, your routine exam is covered. You won't even need a referral from your primary care physician. Routine exams from your primary care physician are also covered.

Depending on your health benefits plan, you may have to pay a small part of the exam cost — a copayment. Please see your *Schedule of Benefits* for the amount of the copayment and the number of routine visits that are covered each year.

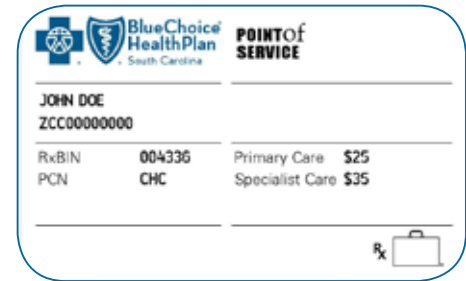
How Your Health Care Coverage Works

Using Your Member ID Card

Whenever you seek medical care, be sure to identify yourself as a BlueChoice HealthPlan member. When you arrive for an appointment, present your BlueChoice HealthPlan membership identification card to the receptionist.

The following is an explanation of each field that may appear on your identification card:

- **ID:** Your BlueChoice HealthPlan identification number.
- **Primary Care:** Your office visit copayment.
- **Specialist Care:** Your office visit copayment.
- **Suitcase:** The suitcase logo indicates that you have Blue Card coverage. If you are traveling and need medical care, the office staff will recognize this suitcase and file your claim.



Routine Visits

Routine appointments are for non-urgent medical needs. These include checkups, follow-up care and camp/school physicals. When making a routine appointment, try to call your primary care physician as far in advance as possible.

Emergency and Urgent Care

Emergency Care: There may be times when you need emergency care. BlueChoice HealthPlan encourages you to call your primary care physician, if possible, before you seek care in an emergency situation.

If it is not possible to call your personal physician, or delaying medical care would make your condition dangerous, please go to the nearest emergency center. If you can't get there on your own, call 911 for assistance. If your area doesn't have 911 services, dial "0" and tell the operator it is an emergency.

Your plan has guidelines for benefits for emergency care services. If you receive emergency care without direction from your personal physician, BlueChoice

HealthPlan will review your case carefully. Please realize that you may be responsible for payment if you receive emergency services that do not meet the guidelines of your plan.

Please review the following information before an emergency occurs so you'll understand your health plan benefits. More information about coverage for emergency care may be found in your *Schedule of Benefits* or *Certificate of Coverage*. Examples of situations that are not considered an emergency include:

- Drug refills
- Removal of stitches
- Requests for a second opinion
- Requests for screening tests or routine blood work
- Routine follow-up care for chronic conditions, such as high blood pressure or diabetes
- Symptoms you have had for 24 to 48 hours or longer such as a cough, sore throat, rash or stuffy nose. You should call your personal physician concerning these conditions.

Conditions that are considered a medical emergency include those so severe that a person with an average knowledge of health and medicine could reasonably expect that if he or she does not get immediate medical attention, one of these conditions could occur:

- Severe risk to one's health, or with respect to a pregnant woman, the health of her unborn child
- Serious damage to body functions
- Serious damage to any organ or body part

A condition is considered to be an emergency if symptoms are severe, appear suddenly and need immediate medical attention. Examples of emergencies include:

- Heart attack
- Stroke
- Poisoning
- Loss of consciousness
- Inability to breathe

All follow-up care must be provided or arranged by a BlueChoice HealthPlan network participating physician in order for you to receive the higher in-network care level of benefits. For example, if you go to the emergency room and get stitches, you should have a network provider remove them when it's time. Returning to the emergency room for stitches removal would result in another copayment if your plan has a copayment for emergency room care.

If you are *admitted* to a hospital, please call BlueChoice HealthPlan within 24 hours or the next workday to prevent denial of your claim. If you are not able to call, please have a family member or friend call for you.

Urgent Care: A condition is considered urgent if it is not life threatening, but still needs immediate attention in order to protect your health. Examples of urgent care conditions include:

- Deep cut to the skin
- Severe diarrhea (without bleeding or dehydration)
- Earache
- Severe sore throat
- Fever
- Acute sinusitis
- Urinary burning, unusual frequency or infection

If you have an illness or injury that requires urgent care, and you cannot get to your personal physician or wait until normal office hours, benefits may be available for services provided at a participating urgent care center. Refer to your *Schedule of Benefits* to determine if urgent care services are

covered under your plan. If they are, you may refer to the BlueChoice HealthPlan provider directory for a list of participating urgent care centers. The provider directory may be found on our Web site at www.BlueChoiceSC.com or you may call Member Services to receive a copy.

Lab Work, X-rays and Pathology

It is important to know that lab work, X-rays and pathology copayment amounts may vary depending on which facility performs the service. If your physician recommends that you or a family member receive one of these services, remind him or her that you are a BlueChoice HealthPlan member and there is a BlueChoice HealthPlan approved facility that should be used.

Prescription Drugs

If your current benefit plan includes prescription drug coverage through BlueChoice HealthPlan (check your *Schedule of Benefits*):

- Most prescriptions from your personal physician or approved specialist are covered, including insulin and related diabetic supplies.
- You must visit a participating pharmacy and show your BlueChoice HealthPlan member identification card in order to receive your prescription drug benefits.
- Please check your *Schedule of Benefits* for details on your copayments and any other restrictions of your health plan benefits.

Your health plan benefits cover prescription drugs at three levels — generic, preferred brand-name drugs and non-preferred brand-name drugs. Generic medications are available at the lowest copayment. Medications that are on BlueChoice HealthPlan's Prescription Drug List are covered at the middle copayment. Medications classified as "non-preferred" are available at the highest copayment. Remember, a copayment is the set amount that you pay each time you fill the prescription.

If your prescribing physician states that your prescription can be filled with a generic drug, but you prefer to use a brand-name drug instead, you will be responsible for the preferred drug copayment and the price difference between the generic drug and the brand-name drug. At no time will you be charged more than the retail price of the medication.

To view a copy of BlueChoice HealthPlan's Prescription Drug List, you may go to our Web site at www.BlueChoiceSC.com, or you may call Member Services and request that a copy be sent to you.

In addition to those listed above, BlueChoice HealthPlan has a discount program for a fourth category of prescription drugs not covered under your policy. These "Lifestyle" medications include prescriptions for hair loss, obesity, contraception, smoking cessation, etc. For a complete list of these drugs, visit the Members section of our Web site at www.BlueChoiceSC.com.

Injectable Medications and Specialty Pharmaceuticals

Some prescription drugs are covered under the Injectable Medications and Specialty Pharmaceuticals benefit. These are drugs that treat complex medical conditions. They include — but are not limited to — intravenous (IV) drugs for chronic disease, injectables and self-injectable drugs for acute and chronic diseases, and oral specialty drugs.

If you need a drug included in the Injectable Medications and Specialty Pharmaceuticals benefit, your physician will arrange for you to get it in one of two ways. Your physician will either administer the drug while you are in the office, or will contact our vendor, NovoLogix, to get the medication for you to use at home. On behalf of BlueChoice HealthPlan, NovoLogix streamlines the management of prior authorizations, claims, and network management processes. NovoLogix is an independent company that manages ancillary services. Specialty Pharmaceuticals that are injectables are not available for coverage through your local pharmacy.

When you receive one of these medications, you will pay a Specialty Pharmacy copayment for each administration in the office setting. If the Injectable Medication is sent to your home for self-administration, you will pay a Specialty Pharmacy copayment for each 31-day supply.

Oral Specialty Pharmaceuticals

Some oral medications, particularly those that are used to treat complex medical conditions, are covered under the Oral Specialty Pharmaceuticals benefit. Oral Specialty Pharmaceutical drugs are covered under your prescription drug benefit, when you have this benefit through BlueChoice HealthPlan. They are available at network pharmacies for a Specialty Pharmaceutical copayment, for each 31-day supply. These medications are not available through a mail-order benefit.

If you have any questions about Specialty Pharmaceuticals or would like a list of the drugs included in this benefit, please contact Member Services by visiting www.BlueChoiceSC.com or by calling 1-800-868-2528.

Vision Care

If your benefit plan includes vision coverage through BlueChoice HealthPlan, vision care will be shown on your *Schedule of Benefits*. If you are not sure whether you have vision coverage, you may contact Member Services. If you need vision care, your plan allows you to self-refer to the provider of your choice.

Behavioral Health

If you have mental health and substance abuse benefits with BlueChoice HealthPlan, Companion Benefit Alternatives (CBA) will coordinate benefits for these services. On behalf of BlueChoice HealthPlan, CBA assists in the administration of the program. CBA is a separate company that administers behavioral health benefits. The CBA network includes a variety of mental health professionals, including psychiatrists, psychologists, licensed social workers and counselors.

To receive services from a mental health or substance abuse professional, you may contact CBA at 1-800-868-1032. If you are currently seeing a physician, the physician can refer you to a mental health or substance abuse professional. He or she will handle all referrals and coordinate your care directly with CBA. Please refer to your *Schedule of Benefits* or *Certificate of Coverage* to find out more information about covered behavioral health services.

What You Pay

Your financial responsibility depends on your individual health plan. The amount you pay for services can be found in your *Schedule of Benefits*.

Below are the different payment categories for which BlueChoice HealthPlan members can be responsible. Take a minute to look over these terms so you will understand the information as it is listed on your *Schedule of Benefits*. Remember, all of these payment categories may not apply to you.

- **Copayment:** The fixed dollar amount you must pay for an office visit, prescription or particular medical service. For example, if your health plan has a \$15 copayment for an office visit, you would be responsible for paying \$15 every time you visit the doctor.

- **Coinsurance:** The percentage of covered expenses you must pay. For example, if your physician charges \$100 for a service and your health plan has a 20 percent coinsurance payment, you would be responsible for paying \$20 and we would pay \$80.
- **Deductible:** The amount of medical expenses you must pay during a particular period of time (usually a year) before certain benefits payable by BlueChoice HealthPlan become effective. For instance, if your health plan has a \$200 deductible for each 12-month period, you would be responsible for paying \$200 worth of medical services within the 12 months before BlueChoice HealthPlan would begin payments.

Please note: Your benefits are subject to all limitations, copayments, deductibles, coinsurance, maximum payment amounts and exclusions in your benefit plan. As a BlueChoice Point of Service member, when you go to a non-participating provider or hospital and use your out-of-network benefits, you will be responsible for all charges above the allowable charges, in addition to any deductible, copayment or coinsurance.

In addition, your physician may recommend that you receive a service that BlueChoice HealthPlan does not cover. If you agree to receive this service, your physician may ask you to sign a waiver. By signing the waiver, you agree to pay the additional charges for the non-covered service.

Explanation of Benefits

After you visit the doctor and we process your claim, you will receive an Explanation of Benefits (EOB) from BlueChoice HealthPlan. This EOB is an important document, and you should save it for future reference.

The EOB will show a breakdown of the charges and payments for your visit. It will also indicate how much of the charges you are responsible for paying. Your physician should not bill you for more than the amount shown in the “What you owe the provider” box on your EOB.

If You Receive a Bill

If you receive what looks like a bill and you followed BlueChoice HealthPlan’s procedures for In-Network or out-of-network care, check first to see if it really is a bill. Many times, you will receive a summary of

services. Somewhere on the document it will say, “This is NOT a bill.”

If you do receive a bill, it should only be for the amount shown on the EOB that we sent you. If the bill is for more than this amount, please contact BlueChoice HealthPlan immediately. We will work to correct any mistake made and notify you of the outcome.

Coordination of Benefits

BlueChoice HealthPlan works hard to control the rising costs of medical care. One way we do this is through Coordination of Benefits (COB). COB is the method of calculating payments between the primary and secondary plans so no more than the actual charges are paid. Without COB, claims would be over-paid and insurance rates would rise. COB allows us to give you all of the coverage you’re entitled to without exceeding the actual cost of the care you received.

If an individual 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 on your medical claim first, while the secondary plan pays only after the primary has paid.

If you are covered by more than one health plan, the EOB you receive following the service breaks down the payment responsibilities between you and your health plans. If BlueChoice HealthPlan is your secondary plan, we must receive an EOB from your primary plan before we can pay our portion of the claim.

Since an individual’s health care coverage can change frequently, we will send you a questionnaire once a year asking if you have other health care coverage in addition to BlueChoice HealthPlan. We will use the information you provide to determine if you qualify for COB and to pay your claims. Please take a moment to complete the questionnaire and return it to us so your claims will be processed quickly and accurately.

Please note: If BlueChoice HealthPlan is your secondary health plan, you must follow the policies and procedures (authorization, referral, etc.) of your primary health plan to ensure payment.

Attention all retirees and those on Medicare:

If Medicare is your primary health plan, we will process the claims and reimburse the Medicare deductibles for hospitals and physicians regardless of whether they are BlueChoice HealthPlan participating providers. We also will reimburse any coinsurance up to 20 percent of the allowed amount that Medicare does not pay. If BlueChoice HealthPlan is your primary health plan, you must see a participating provider and all authorization rules apply.

Verification of Student Status/Incapacitated Dependent

At BlueChoice HealthPlan, we understand that you want to take care of your family, especially your children. That's why we've designed our health plans to be as family-friendly as possible.

In order to remain eligible for health plan coverage through BlueChoice HealthPlan, your dependent child who reaches the age of 19 must:

- Be a full-time student, or
- Have a diagnosed mental and/or physical incapacity.

Your Health Is Important to Us**Preventive Health Guidelines**

Prevention is about staying healthy and free from disease. At BlueChoice HealthPlan, we are here to help you reach these important goals. One way we do this is by making sure you have access to the most current information about prevention. You can find the recommended schedule of preventive health screenings on our Web site at www.BlueChoiceSC.com. These Preventive Health Guidelines are located in the Resources section of our Web site under 10 Tips, Tip #7, or you may contact Member Services to obtain a copy.

Great Expectations® for health

Another way we can help you reach your health goals is through our Great Expectations *for health* programs. These programs are designed to help you improve your medical condition or overall health by providing you with information and professional support. Services provided through these programs may

A full-time student is defined as an unmarried person enrolled at and attending one of the following on a full-time basis:

- An accredited high school or vocational school
- An accredited college or university
- A licensed technical school, beautician school, automotive school or similar training school

For students, we need a letter each year from the registration office of the school showing your child is enrolled full-time. The letter must include the date of enrollment and the number of credit hours your child is taking. If your dependent loses full-time student status or gets married, it is your responsibility to report it to BlueChoice HealthPlan within 31 days.

An incapacitated dependent is an unmarried child who is unable to support himself or herself because of mental retardation, mental illness or physical disability that began before the child reached the age of 19. The child must also be dependent upon you for at least 51 percent of his or her support and maintenance. For incapacitated dependents, we must have a signed doctor's statement describing the disability and prognosis.

include: up-to-the-minute news and information on your condition, check-up and screening reminders, access to telephone counseling with our staff of highly trained health professionals, and free products to help you manage certain chronic conditions.

Great Expectations *for health* offers programs for:

- Asthma
- COPD
- Heart Disease
- Diabetes
- Migraine Management
- Weight Management
- Case Management
- Heart Failure
- Maternity
- Children's Health
- Women's Health
- Men's Health
- Smoking Cessation
- Depression
- Back Care
- Healthy & Active Kids

To learn more about the Great Expectations *for health* programs, including how to enroll, please visit our Web site at www.BlueChoiceSC.com and select "Health and Wellness." If you don't have access to the Internet, you may call us at 1-800-327-3183, ext. 25541 for more information.

Contacting Us

Using Our Web Site

Our Web site is your online resource for health care coverage information. You can read about our health plans and wellness programs and learn how to make the most of your benefits. You can also download forms and search our network directories. Using My Insurance ManagerSM, you can check on your claims and print a copy of your Explanation of Benefits. Below are some of the other tools you will find at www.BlueChoiceSC.com.

My Insurance Manager	My Pharmacy Manager SM
<ul style="list-style-type: none"> • Review the status of your claims • View and print a copy of your Explanation of Benefits • See how much you've paid toward your deductible or out-of-pocket limit • Ask a customer service question through secure e-mail • Request a new ID card • Access My Pharmacy Manager 	<ul style="list-style-type: none"> • View an electronic record of your prescription history • Find consumer information about different medications • Get information about potential therapeutic options to discuss with your physician • Get cost comparison information • Get up-to-date information about your drug benefits <p>If you don't have the pharmacy benefit as part of your health coverage, you'll have limited access to My Pharmacy Manager.</p>

You will need to complete a simple registration process the first time you use My Insurance ManagerSM. Just go to www.BlueChoiceSC.com and select "Members." Select "My Insurance Manager" to open. Select "Create a Profile" in the upper right hand corner of the screen and follow the prompts. Remember to write down your username and password for future reference.

BlueChoice HealthPlan uses My Insurance Manager and the secure e-mail capability to provide information in a way that is safe and convenient for our members. By using My Insurance Manager, you have access to personal benefit information at your convenience. And when you e-mail questions or requests to us, you have a convenient record of your inquiry and our response.

Remember, our Web site is *safe*. Your private informa-

tion stays that way. It's *secure*. Only you have access to any sensitive information about your health coverage. It's *simple*. Just a few keystrokes and mouse selects and you've got the information you need.

Note: We are only able to provide one account per policy. This system is only accessible by using the primary policyholder's date of birth. If more than one person is covered by your policy, you will all share the same account. In cases where a covered family member requests confidential communication due to life threatening situations, information is blocked from being viewed by the subscriber. In this scenario, the person requesting confidential communication must contact Member Services to obtain the information.

Our Commitment to You

Administering Benefits for Appropriate Services

At BlueChoice HealthPlan, we are committed to offering the best available plan of benefits to our members. As part of this commitment, BlueChoice HealthPlan:

- Makes decisions about approving services based on the appropriateness of care and in agreement with your plan of benefits
- Does not compensate or reward any practitioners or other individuals for denying coverage of care or services
- Does not offer any incentives to decision makers to encourage the denying of services
- Monitors the use of services to identify any potential problems of underutilization

Covering New Technology

With so many advances in medical technology and services, have you ever wondered how coverage for a new service is decided? Sometimes a policy may not be in place for a procedure or treatment made available by new technology. In this situation, coverage is considered based on a review of the following resources:

- Recommendations from the Blue Cross and Blue Shield Association's Technology Evaluation Center
- Results from the U. S. Food and Drug Administration (FDA) and other government regulatory review panels
- Review of studies published in peer-reviewed medical journals
- Clinical reviews performed by same specialty physicians from medical review boards external to BlueChoice HealthPlan

BlueChoice HealthPlan's medical director can also seek input from our Clinical Quality Improvement Committee, which is made up of practicing physicians from BlueChoice HealthPlan's network. After reviewing the scientific evidence related to the procedure and its effectiveness, the medical director determines if the procedure or treatment is considered investigational. BlueChoice HealthPlan does not cover investigational procedures or treatments.

Quality Improvement

At BlueChoice HealthPlan, we are proud of the quality service we provide to our members. To maintain our high standards, we have an active Quality Improvement program that oversees quality improvement studies, member satisfaction surveys and member complaints. BlueChoice HealthPlan continuously monitors clinical and service quality issues. We document this process in our annual Quality Improvement Evaluation and Action Plan. If you would like to receive more information about our Quality Improvement program or the annual evaluation, please call 1-800-327-3183.

Rights and Responsibilities

At BlueChoice HealthPlan, we are dedicated to being your partner in health care. We want to ensure you receive the information you need about your health plan, the people providing your care and the services they provide. Knowing this information allows you to be an active participant in your own care. As part of this process, you need to understand your rights and responsibilities as a BlueChoice HealthPlan member. To view a listing of these rights and responsibilities, please visit our Web site at www.BlueChoiceSC.com and select "Members." Select the "Resources" section on the lower left. Then select "Member Rights & Responsibilities" in the right hand column. If you would like to get a copy, you may contact Member Services.

Questions and Concerns

If you have a question or complaint, please contact Member Services. The address and phone numbers can be found on page 1. If you have a question about an authorization, you must notify us within six months from the date we approved or denied the authorization. If you have a complaint about the quality of care you have received, we will start a formal investigation through our Quality Improvement department.

Policies And Procedures

Appeals

At BlueChoice HealthPlan, we are committed to providing you a quick resolution of your concerns. You have the right to appeal if benefits for a health care service are denied and you don't agree with the decision. However, you must appeal the decision within six months of receiving the denial.

You may appeal a decision by calling Member Services or by faxing your appeal to (803) 714-6443. Your appeal must include the following information:

- Your name and identification number
- Information about the denial you are appealing
- Information and comments that support a review of the denial

Once we receive the information, our Appeals department will conduct a complete investigation. The Appeals Review Committee will advise you of its decision in writing within 30 days.

External Review Procedures

The Health Carrier External Review Act, a state law, allows you to ask for an external review in some cases when we deny payment for a claim. Here's how it works:

After you follow our standard appeals process, you may be entitled to another review at our expense — this time from someone who does not work for BlueChoice HealthPlan. To qualify, your case must meet all of the following conditions:

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

If you qualify for an external review, we will inform you in writing and explain the process to follow. You should file the request for external review within 60 days of receiving our notice.

Understanding Your Pharmacy Benefit

The pharmacy benefit can be a complex and confusing part of your healthcare plan. In order to maximize your pharmacy benefit through BlueChoice HealthPlan, it is important that you understand the benefits and limitations associated with it.

Yearly Dollar Benefit Maximum

Your plans may have a maximum dollar amount per year associated with the pharmacy benefit. This means that BlueChoice HealthPlan will only pay up to that dollar limit toward prescriptions each year.

For example: If your plan has a \$2,000 annual maximum benefit, the portion paid by BlueChoice HealthPlan each time you fill a prescription applies toward that maximum. If, at some point during the year, the amount BlueChoice HealthPlan has paid toward your prescription costs reaches that maximum amount, we will no longer pay any portion of your prescription costs from that point on for the rest of the year. As a courtesy, we will send you written notification that you are approaching your pharmacy benefit maximum.

Individual Medication Quantity Limits

Some medications that your physician prescribes may have quantity limits associated with them. This means that each time you fill one of these prescriptions, there is a limit on the number of tablets, doses, etc. that the plan will pay for each month. BlueChoice HealthPlan's Pharmacy and Therapeutics Committee determines quantity limits based on the Food and Drug Administration guidelines associated with each medication. For information on medications and their quantity limits, visit our Web site at www.BlueChoiceSC.com or call Member Services at 1-800-868-2528.

If you believe that there is justification for BlueChoice HealthPlan to forgo a particular quantity limit, you or your physician may submit a request by calling Health Care Services at 1-800-950-5387. We will review your request and make a decision within two business days after receiving all of the necessary medical information. You will be notified of our decision by mail.

Prescription Requiring Prior Authorization

Some medications that your doctor prescribes may require prior approval from BlueChoice HealthPlan before they will be covered by the plan. In order to obtain prior approval, your physician must contact BlueChoice HealthPlan's pharmacy benefit manager at 1-800-294-5979. A drug must meet Food and Drug Administration guidelines in order for prior authorization to be approved. If your physician is prescribing a medication for an "off-label" indication, i.e., one that the Food and Drug Administration has not officially approved for use, prior authorization will be denied. If your physician would like for BlueChoice HealthPlan to reconsider a prior authorization that was denied by our pharmacy benefit manager, they may submit a request by calling Health Care Services at 1-800-950-5387. We will review the request and make a decision within two business days after receiving all of the necessary medical information. You will be notified of our decision by mail.

For a list of medications that require prior approval, please visit our Web site at www.BlueChoiceSC.com or call Member Services at 1-800-828-2528.

Additional Pharmacy Considerations

It is important to remember that BlueChoice HealthPlan only allows prescriptions to be filled for a one-month supply at a time. In addition, we will only allow a one-month supply to be dispensed every 25 days. An attempt to refill a prescription before 25 days have passed will result in your prescription not being filled, so please bear this in mind when you obtain your refills. If you should need to refill a prescription early because of travel or some other emergency situation, please call Member Services at 1-800-828-2528, and a one-time exception may be made.

Submitting Claims

With referred care, you should not have to file claims. Your personal physician or other participating network provider will file your claims for you. However, if you receive self-referred care, you may need to file a claim to ask for reimbursement. All

you have to do is send a copy of the doctor's claim or statement and any supporting information to:

BlueChoice HealthPlan
Member Services
P.O. Box 6170
Columbia, SC 29260-6170

We will review the claim as quickly as possible to determine if the service is covered under your benefit plan.

Privacy Practices

We know it is important to protect the privacy of your oral, written and electronic confidential medical information. The following are some of the steps we take to protect your privacy:

- We require all staff, consultants and business associates to keep any personal health information they acquire confidential. We also require all physicians and other health care providers to protect the confidentiality of this information. They must guard against unauthorized or accidental disclosure of all confidential information.
- We require any organization with which we contract for medical or administrative services to maintain such confidentiality and to have a privacy policy in place that protects against unauthorized use or disclosure of confidential information. All such organizations must sign an agreement attesting that they are compliant with federal privacy regulations.
- We have advanced security systems to limit unauthorized access to information in our computer files.
- We keep all medical information we receive from physicians and other health care providers in a secure area, and we limit access to authorized staff. We also require physicians and other health care providers to keep medical records in a secure area, and we monitor this by conducting on-site visits to their offices.

Please visit www.BlueChoiceSC.com to view our Notice of Privacy Practices. If you'd like a written copy of our privacy practices, you may contact Member Services and request that one be sent to you.

Glossary

ALLOWED AMOUNT – The dollar amount that a health plan determines is appropriate for a covered service. BlueChoice HealthPlan network healthcare providers have agreed to accept the allowed amount as full payment, which means you pay less for your care.

AUTHORIZATION – The approval of medically necessary care by a managed care or insurance company for its member.

BENEFIT – Payment provided for covered services under the terms of the policy. The benefit may be paid to the member, or to others on the member's behalf.

COINSURANCE – Percentage of covered expenses that the member must pay. For example, if your physician charges \$100 for a service and your health plan has a 20 percent coinsurance payment, you would be responsible for paying \$20 of the charges and your health plan would pay \$80.

COPAYMENT – For example, if your health plan has a \$15 copayment for an office visit, you would be responsible for paying \$15 every time you visit your doctor's office.

COVERED SERVICE – Medical service that your health plan will pay for. Covered services are outlined in your *Schedule of Benefits* or *Certificate of Coverage*.

DEDUCTIBLE – The amount of medical expenses that the member must pay during a particular period (usually a year) before certain benefits payable by the health plan become effective. For instance, if your health plan has a \$200 deductible per 12-month period, you would be responsible for paying \$200 worth of medical services within 12 successive months before your health plan would begin reimbursing for covered services.

EXCLUSIONS – Specific conditions or circumstances that are not covered under the contract.

MEDICALLY NECESSARY – Health care services and supplies that are appropriate and necessary based on diagnosis and cost-effectiveness, and that are consistent with national medical practice guidelines as to type, frequency and length of treatment.

NETWORK – The hospitals, physicians and other medical professionals who contract with BlueChoice HealthPlan to provide care for its members. Also referred to as participating or in-network providers.

PARTICIPATING PROVIDERS – Physicians, hospitals, skilled nursing facilities, home health agencies, hospices and other providers of medical services and supplies who agree to participate in the BlueChoice HealthPlan provider network.

POINT-OF-SERVICE PLAN – A type of benefit plan that lets the member choose health services from in-network health care providers or out-of-network health care physicians at the time care is needed, with different benefit levels.

PRIMARY CARE PHYSICIAN – Personal physician the member selects from the BlueChoice HealthPlan network of participating providers to provide or arrange for their health care needs.

REFERRED CARE – Medical care that you receive from, or that is referred by, your primary care physician.

SELF-REFERRED CARE – Medical care that you receive without an authorization. Self-referred care must be both medically necessary and listed as a covered service in your *Schedule of Benefits* in order to receive benefits.

YOUR IMPORTANT HEALTHCARE INFORMATION

Name: _____ Member ID Number: _____

Primary Care Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

Name: _____ Member ID Number: _____

Primary Care Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

Name: _____ Member ID Number: _____

Primary Care Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

Name: _____ Member ID Number: _____

Primary Care Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

Name: _____ Member ID Number: _____

Primary Care Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

Name: _____ Member ID Number: _____

Primary Care Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

Hospital: _____ Phone: _____

Poison Control: _____ Phone: _____

Other Emergency Information:

