

BlueChoice®

POINT of SERVICE

Group Administrator's Manual



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Both are Independent Licensees of the Blue Cross and Blue Shield Association.

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Welcome

Thank you for choosing BlueChoice HealthPlan. The instructions in this manual are intended to assist you in administering your BlueChoice HealthPlan coverage. By studying these guidelines, you will become knowledgeable about the various policies and procedures set forth by this plan.

The policies in this manual generally apply to most groups. Some policies, however, may vary. If you have any questions regarding policy variations, you should refer to your group's contract or consult with your BlueChoice HealthPlan Account Representative for clarification.

Please use this manual as a reference. As we add or revise our policies and procedures, we will update the appropriate section(s) of the manual here on our Web site. We welcome your suggestions and feedback on ways we can improve our service.

Key Points To Remember

- **All additions, deletions and changes to your group membership must be received by BlueChoice HealthPlan within 31 days of the event.**
- **Make sure all information on the Enrollment/Status Change forms is complete.**
- **Follow the participation and probationary period requirements your BlueChoice HealthPlan contract stipulates.**
- **Check the premium invoices carefully each month when you receive them and notify us as soon as possible of any discrepancies or errors.**

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Section 1 — Account Management

1.1 Account Management Team

BlueChoice HealthPlan prides itself on providing high levels of account and member services. We assign to each of our groups an Account Management Team (AMT). Your AMT is responsible for managing the group from the “group leader’s” level. A group leader may be the human resources or personnel contact or some other individual the client firm designates as the liaison between the firm and BlueChoice HealthPlan’s marketing staff.

Your AMT consists of an Account Representative and an Account Coordinator. The Account Representative’s primary responsibility is to provide on-site account service. Examples of these functions include, but are not limited to:

- Scheduling and administration of enrollment meetings
- Periodic client visitation
- Resolving billing inquiries/issues
- Handling eligibility inquiries/issues
- Renewal administration
- Health management program information
- Health fairs
- Special situations or issues

Your Account Coordinator assists you when your Account Representative is unavailable. Call your Account Coordinator for:

- Supplies
- Provider directories
- Enrollment packets
- Forms
- Other questions

Either representative is able to help you administer your BlueChoice HealthPlan plan. Both representatives have a voice message box so you may leave messages at any time. We require all BlueChoice HealthPlan representatives to return calls within 24 hours.

Additionally, your AMT has Internet electronic mail capabilities for inquiries or correspondence. You may contact him or her at firstname.lastname@companiongroup.com.

1.2 Member Services

BlueChoice HealthPlan’s Member Services department performs typical member service functions, including responding to inquires regarding benefits, eligibility, changing primary care physicians, claims inquiries and more. Hours of operation are Monday through Friday (except for holidays) from 8:30 a.m. to midnight Eastern Time. You can reach our Member Services department by phone or the Internet:

By Phone: Toll-free: 1-800-868-2528
 Local (Columbia, S.C.): 803-786-8476

By Internet: www.BlueChoiceSC.com

Service Contact Chart	
Employer Group	BlueChoice HealthPlan Corporation Service Contact
Employer Group Administrator/Representative (Human Resources or Personnel Level)	Account Representative <i>or</i> Account Coordinator
Employer Group Enrollees (BlueChoice HealthPlan Members)	Member Services Department

Section 2 — Benefits and Coverage

2.1 BlueChoice Point of Service

BlueChoice Point of Service is a traditional point of service (POS) plan. The member decides at the time he or she needs medical services whether to go to a provider within BlueChoice HealthPlan's statewide network or seek medical care from a doctor outside the network. With the BlueChoice Point of Service plan, benefits are determined by the member's decision.

Navigating the Networks

In-network

Many benefits, such as coverage for preventive care services, routine health screenings, well-baby and well-child care, are available only when members receive them from healthcare professional in BlueChoice HealthPlan's network. Benefits for other covered services are available at a higher level of coverage when members stay in the network.

To take advantage of the savings the network offers, members must select a participating primary care physician who coordinates all healthcare services covered under your plan. Members have access to their primary care physicians 24 hours a day, seven days a week. And if that doctor isn't available, he or she arranges for another doctor to take care of the member.

When members need to see a specialist or other healthcare professional, their primary care physicians will refer them to one of our network providers. They'll get an authorization stating what services are approved and then we'll cover those healthcare services according to your group's contract.

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 BlueChoice Point of Service, members can enjoy the flexibility of visiting the doctors of their choice — even if they aren't in our network. Their out-of-pocket costs will be a little more, because they may have to pay a copayment, deductible, coinsurance and all charges above our allowable charges. Members may have to file their own claims. Some services, such as preventive care services, may not be covered if the member uses non-participating medical professionals. Please see your schedule of benefits for more information about covered services.

Members may 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, whether or not it is in the network. We do ask that the member or a family member tell the primary care physician and BlueChoice HealthPlan about the emergency as soon as possible.

Section 3 — Membership Enrollment and Changes

3.1 Enrollment

Eligible new employees and their family dependents may elect BlueChoice HealthPlan coverage. Coverage begins when the employee becomes eligible for your company's health benefits and the enrollment form is received by BlueChoice HealthPlan. You should submit an enrollment/status change form within 31 days of the date the employee becomes eligible for coverage. If your company requires a probationary period for new employees, you may 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 as a result of a qualifying event.

Your Account Representative will supply you with enrollment materials, which may include:

- A BlueChoice HealthPlan brochure
- Enrollment/status change forms*
- Summary of Benefits
- A current BlueChoice HealthPlan provider directory**
- Other pieces as required.

* You may download our enrollment forms from our Web site at www.BlueChoiceSC.com.

** You also may find this information at www.BlueChoiceSC.com.

Please review the enrollment form to make sure the employee provides complete information that is consistent with the information on your company records. As the group leader, you will need to insert your appropriate BlueChoice HealthPlan group and subgroup numbers. A sample enrollment form is displayed on the next page.

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. The employee should complete the rest of the form. Depending upon the type of plan offered, each member may need to select a primary care physician. If a member is required to select a primary care physician but submits an application without doing so, we will issue an ID card. We will, however, use the primary care physician listed on the first claim filed for the member, to assign the primary care physician.

The enrollment form also requests information concerning other health benefits the subscriber 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. Send the white copy to BlueChoice HealthPlan, keep the canary copy for your group file, and give the pink copy to the employee. The employee should use this copy as temporary proof of coverage until the permanent ID card arrives.

Please send completed enrollment forms to:

BlueChoice HealthPlan
Attn: Membership, AE-225
P.O. Box 6170
Columbia, SC 29260

ENROLLMENT APPLICATION AND CHANGE FORM

Mail Code: AX-425
P.O. Box 6170
Columbia, SC 29260-6170

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®Registered Marks of the Blue Cross and Blue Shield Association.
SM Service Mark of BlueChoice HealthPlan of South Carolina, Inc.

www.BlueChoiceSC.com

New Enrollment
Effective Date _____

Change
Effective Date _____

Product – Advantage
Advantage Plus
BlueChoice POS
Primary Choice

Low Option
 High Option

A. COMPLETE IF MAKING A CHANGE

ENROLLMENT CHANGE DUE TO:
 Marriage Birth/Adoption Termination COBRA Applicant Divorce GRP # _____
 Death Physician Change Address Change Other _____

B. TO BE COMPLETED BY ALL EMPLOYEES

1. Employee Actively At Work COBRA Retired TYPE OF CONTRACT
 Employee Only Employee/Spouse Employee/Children Employee/Spouse/Children

2. Social Security No. _____ 3. Employee – Last Name First Initial Birthdate Sex: Male Female

4. Mailing Address Street or P.O. Box City State ZIP Code

5. Home Phone Work Phone 6. E-Mail Address:

7. Name of Employer 8. Date of Hire 9. Dept. No.

C. COMPLETE FOR ALL FAMILY MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

Please list all family members to be enrolled or affected by the change. Do not use nicknames. Student verification is required for children who are older than the eligible age for dependent children.

Last Name	First	Initial	Sex	Birthdate Mo. Day Yr.	For Contracts That Require Primary Care Physician Selection Primary Care Physician Name	PCP Code From Directory
YOURSELF:						
Spouse						
Child						
Child						
Child						
Child						

D. OTHER INSURANCE INFORMATION

Are you, your spouse or dependents covered by Medicare or any other health insurance? Yes No If No, do not complete this section.

Name of Person Covered	Name of Health Insurance Co.	Policy #	Eff. Date	Policyholder's Employer

E. COMPLETE FOR LIFE AND/OR DISABILITY Coverage provided by Companion Life Insurance Company

Types and Amounts of Life Insurance Coverage Desired <input type="checkbox"/> Life _____ Supplemental <input type="checkbox"/> AD&D _____ <input type="checkbox"/> Life _____ <input type="checkbox"/> Dep. Life _____ <input type="checkbox"/> AD&D _____ <input type="checkbox"/> STD _____ <input type="checkbox"/> Dep. Life _____ <input type="checkbox"/> LTD _____	Earnings (Check One) <input type="checkbox"/> Biweekly \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly (Amount) <input type="checkbox"/> Weekly <input type="checkbox"/> Annually	Life Class
	Full Name (Last Name, First, Init.): _____ Relationship _____ Primary Beneficiary(ies): _____ Contingent Beneficiary(ies): _____ <small>*SEE INSTRUCTIONS ON BACK FOR MULTIPLE BENEFICIARY DESIGNATION*</small>	

F. COMPLETE FOR DENTAL COVERAGE Coverage provided by Companion Life Insurance Company or by BlueCross BlueShield of South Carolina

Dental Coverage Is For: Employee Employee/Spouse Employee/Children Employee/spouse/Children
 Are you covered by other dental insurance? Yes No If spousal coverage is requested, is your spouse covered by other dental insurance? Yes No

G. EMPLOYEE CERTIFICATION AND STATEMENT OF UNDERSTANDING

I have read the back of this form and agree. I have read and understand each and every part of this form.

SIGNATURE _____ DATE _____

INSTRUCTIONS FOR MULTIPLE BENEFICIARY DESIGNATIONS

- A. If a married woman is to be named as beneficiary, indicate her full given name (example: Mary R. Doe, not Mrs. John Doe).
- B. If two or more beneficiaries are designated, the proceeds will be distributed equally, unless shares are indicated differently by the insured.
- C. When a minor or mentally incompetent person is designated as beneficiary, it will be necessary for a legal guardian to be court appointed before the proceeds can be distributed.
- D. If no beneficiary is designated, or there is no living beneficiary at the time of the insured's death, the proceeds will become payable to the estate of the insured.
- E. Primary Beneficiary – the person to receive life proceeds, if living, at the time of the insured's death. Contingent Beneficiary – the person to receive life proceeds if no primary beneficiary is living at the time of the insured's death.

GENERAL NOTICE OF PRE-EXISTING CONDITION EXCLUSION

This plan may contain a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before that plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to:

BlueChoice HealthPlan
Members Services Department
Post Office Box 6170
Columbia, SC 29260-6170
Or Call
1-800-868-2528
or 803-382-5025 in Columbia

3.2 Changes

No one, except for new hires and new dependents acquired through a qualifying event, may join the plan outside the mutually agreed-upon enrollment period. BlueChoice HealthPlan conducts an annual Open Enrollment period for each employer, usually just prior to the effective date of coverage or renewal date. During this period, employees and their dependents may elect our coverage. Your Account Representative is available to help you plan and conduct your open enrollment. We will assist in the distribution of enrollment literature, conduct informational meetings for your employees and coordinate the processing of applications.

Changes in Employment Status

Termination of Employment — BlueChoice HealthPlan’s coverage ends at the end of the month following termination of employment or earlier based on your company’s policy. Retroactive deletions are acceptable if received within 31 days of the member’s coverage termination, and if the member had no benefit payments during that period. If benefits were paid during such period, premiums are due and payable through the end of the month in which benefits were provided. See Sections 3.9 and 3.10 for coverage continuation options.

Layoffs/Leaves of Absence — Members who you lay off or who have a leave of absence from their place of employment may be able to continue their BlueChoice HealthPlan coverage on a group/individual basis.

Changes in Family Status

Please notify BlueChoice HealthPlan of any changes in a family’s status within 31 days of the qualifying event. You will use the Enrollment/Status Change form to terminate a family member.

Please remember — the enrollment/status change form must contain the subscriber’s name, address, Social Security number and requested effective date. The subscriber or group leader should check the “enrollment change due to” box and indicate the reason for termination (divorce, death, other).

The subscriber should list each dependent he or she wishes to disenroll in the same section of the enrollment form as the original (for example — spouse 02, first child 03, second child 04). The subscriber should include the dependent’s full name, gender and date of birth.

3.3 Qualifying Events

BlueChoice HealthPlan recognizes the following qualifying events as reasons to change status outside of the Open Enrollment period:

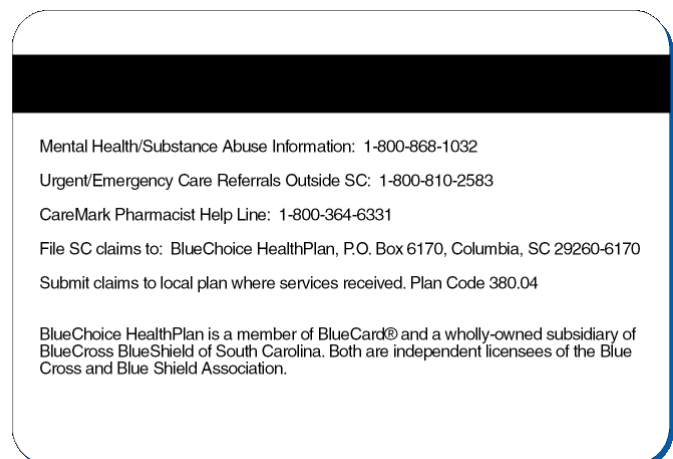
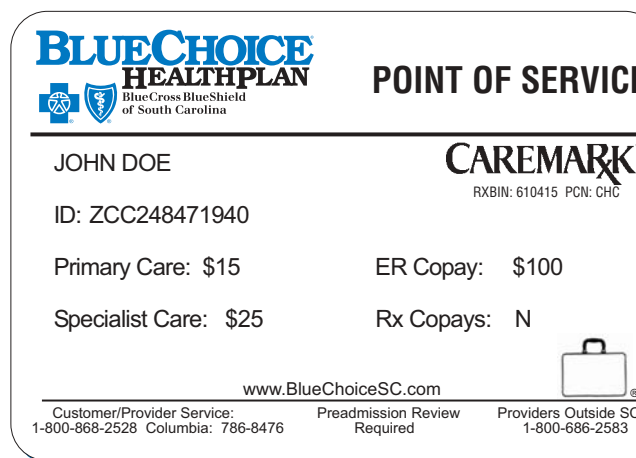
- Birth.
- Marriage/divorce.
- Death.
- Legal adoption.
- Addition of stepchildren or foster children.
- Permanent legal custody.
- Spouse's loss or gain of employment and insurance coverage, with the following requirements:
 - (1) Spouse's employer sends written notification to BlueChoice HealthPlan of the spouse's loss or gain of employment or insurance.
 - (2) The spouse's gain of employment and insurance coverage allows the subscriber 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 subscriber to add the spouse and other eligible family members previously covered by the spouse.
- Reinstatement of civilian status.

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

3.4 Member Package

Once we have processed the enrollment form, we will send the enrollee a Member Package that includes the following:

- Certificate of Coverage — information about your contract with BlueChoice HealthPlan. It reflects the benefits and limitations of your plan.
- Schedule of Benefits — 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 your group has purchased.
- Member Guide - information that reflects the benefits, limitations and responsibilities of both the member and the plan.
- BlueChoice HealthPlan ID card — The member should verify all information on the front of the card and carefully read the information on the back. The member should carry the card with him or her at all times and present it whenever he or she receives medical services.



Description of ID Card codes:

ID NUMBER - your BlueChoice HealthPlan identification number

Primary Care - primary care physician copayment

Specialist Care - specialist care copayment

Rx Copays - generic/preferred/non-preferred drug copayment

ER Copay - emergency room copayment

Urgent Care - urgent care copayment

M/H - mental health copayment

VIS - indicates if you have routine vision coverage (will not appear if no coverage offered)

CareMark - if you have pharmacy coverage through BlueChoice HealthPlan, your retail pharmacy copayments are indicated above this logo.

BlueCard® - The suitcase picture on your member identification card indicates you have BlueCard® coverage, which provides coverage for follow up and urgent care while traveling outside of South Carolina.

Note: Some employers may have customized ID cards. Information on those cards may be different than shown above.

3.5 Health Insurance Portability and Accountability Act (HIPAA)

To comply with HIPAA, when an employee terminates coverage or COBRA terminates, BlueChoice HealthPlan will generate a Certificate of Creditable Coverage, which will be mailed to the employee's home. These also may be generated 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 — 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 your Account Representative to indicate your preference for any of the services listed above.

A sample Certificate of Creditable Coverage and Pre-existing Condition Exclusion Notice Letter are shown on the following pages.



P.O. Box 6170
Columbia, SC 29260-6170

www.BlueChoiceSC.com

CERTIFICATE OF HEALTH COVERAGE

* IMPORTANT — This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan, or the South Carolina Health Insurance Pool (SCHIP), that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care or treatment was recommended or received for the condition within the six-month period prior to your enrollment in the new plan. If you become covered under another group health plan or SCHIP, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate:
2. Name of last health plan:
3. Name of participant:
4. Identification number of participant:
5. Name of person to whom this certificate applies:
6. If there has been at least 18 months of creditable coverage (not counting lapses of coverage of more than 63 days), check here _____ and skip lines 7 and 8.
7. Date waiting period began:
8. Date coverage began:
9. Date coverage ended: _____ (or check here if coverage is continuing as of the date of this certificate: _____)

(803) 786-8466 (800) 327-3183



P.O. Box 6170
Columbia, SC 29260-6170

DUPLICATE COPY

www.BlueChoiceSC.com

DATE: mm-dd-yy

Subscriber's Name
Subscriber's Address
City, State ZIP

ID#
Group Health Plan:

Dear Subscriber Name:

This letter serves to let you know when the pre-existing condition exclusion in your BlueChoice HealthPlan insurance policy will end. We are sending this letter to you in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Your pre-existing condition exclusion will end at midnight on ____.

This means that benefits will not be available until after the date listed above for services or supplies related to any medical condition (other than pregnancy) for which medical advice, diagnosis, care or treatment was received or recommended within six months immediately prior to your enrollment date.

We determined this date from any certificate(s) of creditable coverage and other information received about insurance coverage you had before this policy.

If you have other information that you think could change the date your pre-existing condition exclusion should end, please send it as soon as possible to the following address:

BlueChoice HealthPlan
Membership Services
P.O. Box 6170
Columbia, South Carolina 29260-6170

We will carefully review the information you send us to see if it will change our current decision. We will send the results of our review to you in writing, along with any other effective date that may apply. We have the right to reconsider your pre-existing condition status at any time, but we will always send you a letter if there are any changes.

If you have any questions, please call us and we will be happy to assist you.

Sincerely,

BlueChoice HealthPlan
Membership Services

(803) 786-8466 (800) 327-3183

3.6 Student Verification

For most accounts, a dependent child who reaches the age of 19 must be (A) a full-time student or (B) have a certifiable mental and/or physical incapacity in order to remain eligible for coverage.

(A) A full-time student is a person enrolled in and attending on a full-time basis a recognized course of study or training at:

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

It is the employee's responsibility to report any dependent who loses full-time student status to BlueChoice HealthPlan within 31 days.

(B) An incapacitated dependent is an unmarried child who is incapable of self-support because of mental retardation, mental illness or physical incapacity which began before the child reached age 19, and who is dependent upon the subscribers for at least 51% of support and maintenance.

Some accounts handle dependent verification themselves. For those where BlueChoice HealthPlan handles the process, we require a letter from the registration office of the school, indicating that the dependent is enrolled full-time beginning with a specified date and the number of hours they are taking. For incapacitated dependents, we must have a signed doctor's statement.

When the information is needed, we notify the subscriber in one of two ways:

1. We send a letter requesting the information for a dependent that has reached or is near age 19 (a copy of that letter is shown on the next page); or
2. If a claim is filed, the explanation of benefits (EOB) will state that we need to verify dependent eligibility before we can process the claim.

In either situation, the subscriber must submit the necessary paperwork within 31 days so the dependent does not have a lapse in coverage. Once the information is loaded into our system, it is valid for one year.



P.O. Box 6170
Columbia, SC 29260-6170

www.BlueChoiceSC.com

DATE: mm-dd-yy

Subscriber's Name
Subscriber's Address
City, State ZIP

ID#
GROUP #

RE: Dependent's Name

AGE: _____ D.O.B. _____

Dear Subscriber's Name:

BlueChoice HealthPlan's records indicate that the dependent, named above, has reached or is near the maximum coverage age of 19. Therefore, this child must meet additional criteria in order to continue as an eligible dependent under your coverage.

Eligible dependents are dependents who are full-time students or who have a certifiable mental and/or physical incapacity. Please refer to your certificate of coverage or explanation of benefits for a definition of "eligible dependent."

In order to continue as an eligible dependent, please attach to this letter a signed statement from the school confirming your dependent's enrollment as a full-time student, or a doctor's signed statement regarding your dependents mental and/or physical incapacity. You must return this information within 31 days of receipt of this letter to avoid a lapse in coverage. We have included a pre-addressed, postage paid envelope for your convenience. Without this required documentation, coverage for your dependent will terminate on _____.

Sincerely,

Member Services

Enclosure

(803) 786-8466 (800) 327-3183

3.7 Termination of Group Contract

Except as provided in this section, if BlueChoice HealthPlan offers coverage in the large group market in connection with a group health plan, it will renew or continue in force such coverage at the option of the employer. BlueChoice HealthPlan may non-renew or discontinue its offer of healthcare coverage in connection with a group health plan in the large group market based only on one or more of the following:

1. **Non-payment of premiums** — The employer has failed to pay prepaid fees or contributions according to the terms of the contract. Or, BlueChoice HealthPlan has not received timely prepaid fees. The contract, and all certificates issued thereunder, shall automatically terminate without notice on the 31st day following a prepaid fee due date, unless the full prepaid fee is received by BlueChoice HealthPlan at its home office no later than the 30th day after its due date. The contract shall continue in force during that 31-day period and 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, BlueChoice HealthPlan has 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. BlueChoice HealthPlan may discontinue offering this particular type of coverage provided it:
 1. Provides notice to each employer that provides the coverage and the covered members of the discontinuation at least 90 days before coverage ends;
 2. Offers to each employer providing the coverage the option to purchase any other health insurance coverage BlueChoice HealthPlan currently offers to a group health plan; and
 3. Acts 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. BlueChoice HealthPlan may elect to discontinue offering all health insurance coverage in this state if:
 1. Notice is provided to the Director of Insurance and to each employer and covered member of the discontinuation at least 180 days before coverage ends; and

2. All health insurance coverage issued or delivered in this state in such market is discontinued and coverage under the health insurance coverage in the market is not renewed. BlueChoice HealthPlan 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 any enrollee in connection with this plan who lives, resides or works in the local service area of BlueChoice HealthPlan or in the area for which BlueChoice HealthPlan is authorized to do business.

3.8 Termination of Employee Contract

When an employee becomes ineligible for your group's health coverage, please complete an enrollment/status change form to terminate the member's contract with BlueChoice HealthPlan. We must receive this form within 31 days of the qualifying event, as we do not accept retroactive disenrollment.

The enrollment/status 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 benefits were paid after the requested termination date, prepaid fees are due and payable through the month in which benefits were provided.

3.9 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. BlueChoice HealthPlan will require the employer to submit a completed and signed enrollment/status 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.

3.10 Conversion to Non-group Policy

Members without COBRA options who continue to reside in the BlueChoice HealthPlan service area may be able to convert to an individual policy. Employees may not have had any lapse in coverage or 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 copayment schedule for this benefit plan are available upon request. Premium rates and benefits are subject to change.

To continue benefits, we must receive the Enrollment/Status Change form indicating conversion within 31 days of the loss of coverage. We also require payment for the first quarterly premium to be submitted with the form.

Section 4 — Invoice Guide

4.1 Invoice Guide

BlueChoice HealthPlan issues group bills prior to the effective month of coverage. **Payment is due and payable on or before the first day of the month.** Please pay your bill promptly to avoid any unnecessary inconveniences.

There are four parts to your BlueChoice HealthPlan invoice.

Part 1 — Subscriber Reconciliation List

This shows each employee for whom we have received a membership application.

The invoice shows the employee's

- ❶ subscriber name and number
- ❷ Social Security number
- ❸ coverage type (S=single, D=double, P=employee and child, F=family), the
- ❹ number of members
- ❺ premium amount.

BlueChoice HealthPlan Midlands Region Columbia, SC 29260-6000 (803) 786-8466					
05-19-00 999*01 Test Group ***SUBSCRIBER RECONCILIATION LIST*** 06-01-00 thru 06-30-00					
❶	❷	❸	❹	❺	
SUBSCRIBER	NAME	SS#	CONT TYPE	MEMS	PREMIUM
443556211	Adams, H.	443556211	P	3	300.00
255448899	Cook, J.	255448899	D	2	250.00
555841233	Jones, K.	555841233	S	1	100.00
123456789	Smith, J.	123456789	F	5	450.00
Total					❻ 1,100.00

Part 2 — Group Statement

The top portion summarizes your ❶ company's name, address and contact person ❷ statement number ❸ statement date ❹ payment due date ❺ coverage period. **Please include the statement number on your check when you send your premium.**

The bottom portion shows

- ❻ premiums for active subscribers
- ❼ retroactive adjustments (any changes in coverage and resulting adjusted premiums)
- ❸ premium due for active subscribers
- ❹ any unpaid balance
- ❺ total amount due.

Please pay the total amount due in full to avoid any reconciliation problems.

Under the terms and conditions of our contract, we will retroactively adjust your account when you notify us of membership changes.

We do not accept handwritten additions, deletions or corrections to bills to make enrollment changes. Please submit an enrollment/status change form for these adjustments.

BlueChoice HealthPlan Midlands Region Columbia, SC 29260-6000 (803) 786-8466			
GROUP STATEMENT			
❶ Contact Test Group	❷ Statement Number		4212624
	❸ Statement Date		05-17-00
	❹ Due Date		06-01-00
	❺ Coverage Period		06-01-00 to 06-30-00
999*01			
❻ Premiums for Active Subscribers This Period			
1	Single	@ 100.00	100.00
1	Double	@ 250.00	250.00
1	P & CH	@ 300.00	300.00
1	Family	@ 450.00	450.00
			1,100.00
❼ Retroactive Adjustments			0.00
❸ TOTAL PREMIUM FOR ACTIVE SUBSCRIBERS THIS PERIOD			1,100.00
❹ UNPAID BALANCE FROM PRIOR PERIODS			0.00
❺ *****TOTAL AMOUNT DUE*****			1,100.00
Please note that any changes received after the statement date above will be reflected on your next billing. Please submit changes by the 10th of each month.			

Part 3 — Remittance Copy

This is the page you return with your premium check. Remember to include the ★ statement number on your check. Please notify us if your group premium will be late.

If we do not receive your payment before the 30-day grace period ends, action will be taken to quickly recover the amount due. All claims payments for dates of service on or after the due date will be pended until your account is paid current or your coverage may be cancelled. If you have any questions concerning your account, please call your Account Representative or our Billing department at (803) 786-8466 or 1-800-868-2528.

REMITTANCE COPY			
Please return this page with your payment. This will ensure proper credit to your account.			
PLEASE PAY \$1,100.00			
Enter the amount of your enclosed payment here. \$ _____			
Test Group			
GRP NO	999*01		
Due Date	06-01-00 ★Statement Number 412624		
<table border="1"><tr><td>BlueChoice HealthPlan P.O. Box 6170 Columbia, SC 29260-6170</td><td>Please send your payment to this address.</td></tr></table>		BlueChoice HealthPlan P.O. Box 6170 Columbia, SC 29260-6170	Please send your payment to this address.
BlueChoice HealthPlan P.O. Box 6170 Columbia, SC 29260-6170	Please send your payment to this address.		

Part 4 — Retroactive Adjustments

The adjustment statement will reflect changes in your members' contracts during a given time period. The statement you receive will have member names listed in alphabetical order.

On the statement, you will find ❶ effective dates at the top. The bottom portion shows

- ❷ subscriber numbers
- ❸ beginning and end dates
- ❹ the number of person(s) covered
- ❺ number of members
- ❻ the previous contract type
- ❼ previous premium
- ❽ the new contract type
- ❾ the amount the premium should have been
- ❿ the adjustment amount.

BlueChoice HealthPlan Midlands Region P.O. Box 6000 Columbia, SC 29260-6000 (803) 786-8466									
Retroactive Adjustments ❶ 09-01-00 thru 09-30-00									
❷ Subscriber Number	❸ Beg. Date	End Date	❹ # Pers	❺ Nbr. Mem.	❻ Bill Cont.	❼ Was Prem.	❽ Cont.	❾ Should Prem.	❿ Adjust
123456789	08-01-00	08-31-00	1	1			S	175.50	175.50
012345678	08-01-00	08-31-00	1	3			F	525.50	525.50
901234567	08-01-00	08-31-00	1	4	F	525.50	P	367.50	-158.00
890123456	07-01-00	07-31-00	1	1			S	175.50	175.50
	08-01-00	08-31-00	1	1			S	175.50	175.50
678901234	07-01-00	07-31-00	1	1	S	175.50			-175.50
	08-01-00	08-31-00	1	1	S	175.50			-175.50
TOTALS								❾	543.00

Section 5 — Claims and Member Services

5.1 Member Billing

BlueChoice HealthPlan's participating physicians, hospitals and other providers bill us directly. A member makes copayments at the time of service and should not receive any bills. If a member receives a bill for anything other than copayments, deductible or coinsurance, he or she should submit the bill to BlueChoice HealthPlan's Member Services department. 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.

Understanding Your Explanation of Benefits (EOB)

Your Explanation of Benefits, or EOB, is a form we send you that gives you details about your claims' status. It features important information about services you received, how much we covered, how much you may owe your provider and much, much more.

You'll notice we've gathered most of the quick details you're looking for in a convenient Summary Information box. Details about your claims are in column format, so you can easily track the information about each service you received. We've also included helpful definitions on each and every EOB, so you'll know more about what you're reading!

This convenient guide will walk you through a typical EOB. Thank you for allowing us to serve you!

EXPLANATION OF BENEFITS (EOB)

1234

(ADDRESS)

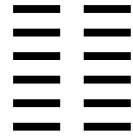
EXPLANATION OF BENEFITS

THIS IS NOT A BILL

If you have a question about your claim, please call Customer Service at (PHONE NUMBERS AND HOURS)

1

(DATE)



JOHN DOE
PO BOX 0000
ANYWHERE, SC 12345

2 SUMMARY INFORMATION

3 CHECK NO.: 123456789

4 Patient's Name JONATHAN DOE	5 Relationship to Policyholder CHILD	6 ID No. 123456789	7 Claim No. 123456789-99-99
8 TOTAL CHARGE FOR YOUR CLAIM: 870.85	9 TOTAL AMOUNT WE PAID: 522.51	10 WHAT YOU OWE PROVIDER: 130.63 The provider can bill you for this amount if you have not yet paid.	
11 To date, you have satisfied 250.00 of the 250.00 deductible for the benefit period that began 07/24/1999.			
This claim contributed 130.63 toward your out-of-pocket maximum. You have satisfied 1,072.04 of the 2,000.00 out-of-pocket maximum for this benefit period. We have paid a total of 4,555.54 for this person this benefit period.			

DETAIL INFORMATION

12 Provider	BC HOSPITAL	BC HOSPITAL	BC HOSPITAL
13 Network Participation	YES	YES	YES
14 Dates of Service	09/01/99	09/01/99	09/01/99
15 Type of Service	OUTPT RADIOLOGY	OUTPT LAB/PATH	OUTPATIENT HOSPITAL
16 Charge	89.00	123.87	657.98
17 Amount Not Covered	22.24 01*	30.97 01*	164.50 01*
18 Covered Expenses	66.76	92.90	493.48
19 Deductible	.00	.00	.00
20 Copayment	.00	.00	.00
21 Allowed Amount	66.76	92.90	493.48
22 Coinsurance	13.35	18.58	98.70
23 Amount Paid	53.41	74.32	394.78

24 *Please refer to the remarks section.

Suspect claims fraud? Please help by calling our hotline at 1-800-763-0703

THANK YOU FOR ALLOWING US TO SERVE YOU!

PAGE 001

(Web Site Address)

25 Helpful Definitions (Please check your schedule of benefits in your benefit booklet for details.)

Amount Approved for Coordination — the amount we will coordinate with your primary health or dental plan's payment.

Benefit Period — the period of time you must pay any deductibles and coinsurance payments that may apply. Benefits begin once you meet the deductible. If you reach the limit, we pay covered expenses in full for the rest of the benefit period. Deductibles and coinsurance start over with each new benefit period.

Coinsurance — the percentage of the allowed amount you pay as your share of the bill. If your plan pays 80%, then 20% would be your coinsurance.

Copayment — a set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible — the amount, if any, that you are responsible for paying before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on the claims you and healthcare professionals send to us.

Less Benefit Limitation — the amount that is more than your contract allows for this type of service. Your plan covers these services until you have reached the limit of your benefits.

Network Participation — this column shows whether or not the healthcare professional who provided the service participates in our network. If "YES," this is a network participant. If "NO," this is not a network participant. If "N/A," the issue doesn't apply to your coverage, or this particular claim.

Out-of-pocket Maximum — the highest amount of covered expenses you will have to pay during a benefit period.

Total Benefit Allowed — the amount we would have paid if another insurance carrier was not involved.

26 APPEAL OR REVIEW (APPEALS INFORMATION)

27 Remarks Section

01 THIS AMOUNT REPRESENTS THE DIFFERENCE BETWEEN THE ACTUAL CHARGE AND THE PRE-NEGOTIATED REIMBURSEMENT AMOUNT. YOU ARE NOT RESPONSIBLE FOR THESE NON-COVERED CHARGES.

Route Code: B2N
Group Number: 123456789

- Customer Service Information — If you have a question about your coverage or the information on your EOB, here's how to contact us.
- Summary Information — This box gives you important information at a glance.
- Check Number — This number helps our customer service representatives quickly track a check in case you have questions regarding payment. This field will only show if we are making a payment to the member.
- Patient's Name — The name of the person who received a service. This could be you, your spouse or a dependent child who has coverage under your health plan.
- Relationship to Policyholder — This is the patient's relationship to the member.
- ID Number — The covered policyholder's number. Please have this number handy when you call customer service.
- Claim Number — The number we assigned to your claim so we can track it.
- Total Charge for Your Claim — The amount the provider charged for this claim.
- Total Amount We Paid — The amount we paid for the entire claim, based on your coverage.
- What You Owe Provider — The amount, if any, you need to pay the provider for this claim. There may be times when you don't owe anything.
- Deductible and Out-of-Pocket Summary — This area explains how much you have paid toward your deductible, if applicable. It shows how much of this claim went toward your out-of-pocket expenses and how much you've paid toward your out-of-pocket maximum so far this benefit period. It also shows how much we've paid in benefits for the patient during this benefit period.
- Provider — The healthcare professional or facility that provided services to the patient.
- Network Participation — Whether or not the provider the patient visited participates in our network.
- Dates of Service — When the patient received services.
- Type of Service — A description of the type of service for each claim.
- Charge — The amount the provider charged for the service.
- Amount Not Covered — The amount, if any, for non-covered services or the amount that is above the allowed charge.
- Covered Expenses — The amount considered for benefits after any non-covered charges have been subtracted.
- Deductible — The amount, if any, you pay to providers for services each benefit period before we start paying our share. You do not send this amount to us. We subtract this amount from covered expenses on the claims you and providers send to us.
- Copayment — The set fee you pay each time you receive a certain service. Some plans do not have copayments.
- Allowed Amount — This is the amount from which your coinsurance, if applicable, will be determined.
- Coinsurance — The percentage of covered expenses you pay as your share of the allowable amount. An allowable amount is the most a plan will pay for a covered service. For example, if your plan pays 80%, then 20% would be your coinsurance.
- Amount Paid — The amount we paid, based on your coverage.
- Remarks Note — Shows where to look for reasons.
- Helpful Definitions — We've included some definitions to help you better understand your EOB.
- Appeal or Review Information — How to file an appeal if you disagree with our decision.
- Remarks Section — This section explains any Remarks in the Amount Not Covered field (17).

5.3 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). The Department of Insurance sets and regulates guidelines on COB. Managed care organizations and insurance companies alike follow these guidelines when an individual has coverage from more than one health plan. COB reduces costs by eliminating double payment of benefits. Employers and employees who pay premiums share in these savings.

COB generally applies to members who are subscribers under one health plan and dependents under another one. The COB guidelines determine the exact order of payment between BlueChoice HealthPlan and the other insurance carrier. The Explanation of Benefits (EOB) breaks down the payment responsibilities of the insurance carrier and the member. If BlueChoice HealthPlan is the secondary carrier, we must receive an EOB from the member's primary carrier before we can pay the claims as the secondary carrier.

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: Even if BlueChoice HealthPlan is the secondary carrier, the member should follow our policies and procedures (network providers, referrals, etc.) to receive benefits. If an employee receives a COB questionnaire from us, please advise him or her to complete it and return it to us promptly. Payment of claims depends on this important information.

5.4 Medicare Coordination

When BlueChoice HealthPlan covers active employees with Medicare:

- For employers with 20 or fewer employees, Medicare is the primary carrier.
- For employers with more than 20 employees, BlueChoice HealthPlan is the primary carrier.

BlueChoice HealthPlan is also the primary carrier for retired employees with Medicare coverage who remain on the active group policy. We will coordinate benefits with Medicare.

5.5 Subrogation

BlueChoice HealthPlan has the right of subrogation. This means we may recover from a third party the cost of a member's healthcare for injuries or illnesses the other party was responsible for. If the member received a settlement (as a result of an accident or legal claim), BlueChoice HealthPlan may seek recovery from the member or the third party.

5.6 Appeal Procedures

To appeal a decision regarding the provision of benefits under your Contract, the Member may contact a representative of BlueChoice HealthPlan stating the issue to be reviewed and attaching pertinent medical records or other information that the Member offers in support of the appeal. The Member also may request a description of any pertinent records that the Corporation 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 request should be addressed to the chief operating officer of BlueChoice HealthPlan Corporation. If a complaint is related to the quality of care received by a Member, it is considered a grievance. The Member should submit a description of the problem in writing to a BlueChoice HealthPlan representative.

A BlueChoice HealthPlan representative will notify the Member of receipt of the complaint or appeal and will arrange for a review by an appropriate representative of the Corporation. A complaint or appeal shall be resolved within thirty (30) days from the date received. This period may be extended in the event of a delay in obtaining 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 may request that the individual who reviews the request be a person who did not make the initial decision of denial. The Member may 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 may request an expedited appeal. For an expedited appeal, a decision shall be made and the Member shall be notified of the decision within two (2) business days of the Corporation's 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 may resubmit the appeal through the standard appeal process.

All claims, questions, grievances, or appeals must be submitted within six (6) months after the later of the date services were rendered or the date the claim for services was denied. After the expiration of this period, disposition of the claim shall be considered final. Any question or appeal a Member has concerning an Authorization must be made to BlueChoice HealthPlan within six (6) months from the date the Authorization was approved or denied by BlueChoice HealthPlan or the decision shall be considered final.

External Review by an Independent Review Organization

In certain situations, a Member may be entitled to an additional review of the appeal at the Corporation's expense. An external review may be used to reconsider the appeal if the Corporation has denied it either in whole or in part; if the payment would be greater than five hundred dollars (\$500.00); and if a requested service or payment for service has been denied, reduced, or terminated. These situations include a decision by the Corporation that the requested service:

1. does not meet the requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; or
2. is experimental or investigational, and involves a condition that is life-threatening or seriously disabling.

After all internal appeals are completed, the Member will be notified in writing of the right to request an external review. The Member should file a request for review within sixty (60) days of receiving that notice.

The Member will be required to 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 Director of the South Carolina Department of Insurance or his designee may be contacted at the following address and telephone number:

South Carolina Department of Insurance
P.O. Box 100105
Columbia, SC 29202-3105
1-800-768-3467

Within five (5) business days of the request for an external review, the Corporation must respond by either:

1. assigning the review and forwarding records used in making the decision to an independent review organization; or
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 forty-five (45) days after receipt of 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 that would place the Member's health in serious jeopardy. The Member also may receive an expedited review if the denial involves an Emergency Admission or Emergency care; if the Member has not been discharged from a facility after receiving that care; and if the Member will be held financially responsible.

5.7 Member Services

BlueChoice HealthPlan's Member Advocates are available to answer your employees' questions and help them understand their benefits. Here are just a few of the areas they can assist you in:

- Choosing or changing a primary care physician
- 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: 1-800-868-2528 (In Columbia, call 786-8476.)

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

Internet: www.BlueChoiceSC.com

5.8 Voice Response Unit

BlueChoice HealthPlan has an automated Voice Response Unit (VRU) available to members and providers 24 hours a day, 365 days a year. The VRU is accessed by calling 1-800-868-2528 or locally (in Columbia, SC) at (803) 786-8476.

Members can check the following information through the automated system:

- Claims status
- Eligibility
- Benefits
- Request a member guide, provider directory or certificates of coverage

5.9 Web Site

BlueChoice HealthPlan's Web site is available to all with Internet access. Our Web address is www.BlueChoiceSC.com. You may use the Web site for many things, including the following:

- Initiate Member Services inquiries
- Get product information and make inquiries
- Search our provider directory for participating medical providers or facilities
- Download forms to use
- Check out our **Great Expectations® for health** programs
- Review legislative updates relating to health coverage
- Read recent press releases
- Review our Member Guide
- Review a generic copy of this Group Administrator's Manual
- Use **My Insurance Manager**, a safe and private interactive member services tool
 - Review claims status, deductible and out-of-pocket limits
 - View and print Explanation of Benefits
 - Request ID cards
 - Depending on coverage, change primary care physicians
 - Use secure e-mail to ask customer service questions
- Visit **Natural Blue**, our complementary and alternative medicine discount program

Section 6 — Accessing Medical Services

6.1 Obtaining Healthcare Coverage

BlueChoice Point of Service is a traditional point of service (POS) plan. A member decides at the time he or she needs medical services whether to go to a doctor within BlueChoice HealthPlan's statewide network or seek medical care from a provider outside the network. With the **BlueChoice Point of Service** plan, benefit levels are determined by that decision.

In-network, **BlueChoice Point of Service** uses primary care physicians to manage members' healthcare. A primary care physician may be a family or general practitioner, a general medicine doctor or a pediatrician. Each member may choose his or her own primary care physician. An enrollee does not have to select only one for the entire family.

Navigating the Networks

In-network

Many benefits, such as coverage for preventive care services, routine health screenings, well-baby and well-child care, are available only when members receive them from healthcare professionals in BlueChoice HealthPlan's network. Benefits for other covered services are available at a higher level of coverage when members stay in the network.

To take advantage of the savings the network offers, a member must select a participating primary care physician who coordinates all healthcare services covered under your plan. Primary care physicians in the BlueChoice HealthPlan network are available 24 hours a day, seven days a week. If a member's personal 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 healthcare professional, the primary care physician will refer him or her to one of our network providers. The member will get an authorization stating what services are approved and then we'll cover those healthcare services according to your group's contract.

There are other advantages to using in-network doctors. These doctors file claims for covered expenses for members. Our members pay only the copayment, deductible and coinsurance amounts, if any, for covered expenses. The network doctors accept our payment as payment in full for covered expenses, minus the out-of-pocket expense, if any.

Out-of-network

With **BlueChoice Point of Service**, members can enjoy the flexibility of visiting the doctors of their choice — even if they aren't in our network. Out-of-pocket costs will be a little more, because members may have to pay copayments, deductible and coinsurance, and they may have to file their own claims. Some services, such as preventive care services, may not be covered if members go outside the network. Please see your schedule of benefits for more information about covered services.

A member may seek emergency care from out-of-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, he or she needs to go to nearest hospital or treatment center, whether or not it is in the network. We do ask that the member or a family member tell the primary care physician and BlueChoice HealthPlan about the emergency as soon as possible.

6.2 Primary Care Physicians

We ask that members select a primary care physician from our provider network. A primary care physician may be a family or general practitioner, an internal medicine doctor or a pediatrician. That physician becomes the member's healthcare manager, coordinating all the member's medical care. BlueChoice HealthPlan has contracted with physicians throughout the state, and many members will be able to find their current doctors in our network. Please consult our current provider directory or our Web site directory for a listing.

If a member chooses a new primary care physician, he or she should be careful to note any restrictions in the provider directory. Some of our physicians will accept current patients only or patients of certain ages. We update our directory periodically. Our Web site directory is updated nightly. You or your employees also may call our Member Services department to verify a physician's current status with BlueChoice HealthPlan.

Each member may choose his or her own primary care physician; a family does not have to select only one for the entire family. For example, the mother may choose a family practice physician, while the father selects an internal medical physician. They may then select a pediatrician for their children.

6.3 Obstetricians and Gynecologists

Our female members may choose to see a contracting OB/GYN twice a year (depending on your group contract). The member does not need a referral from her primary care physician for the visits. The member should make an appointment directly with the OB/GYN.

The routine gynecological examination includes the office visit and medically necessary laboratory tests. We cover basic lab tests the physician may perform in the office. The physician must forward all other tests, including Pap smears, to a BlueChoice HealthPlan designated laboratory. The lab will bill us directly. The member will be responsible for making the copayment at the physician's office.

6.4 Changing a Primary Care Physician

Members may change their primary care physicians at any time. The member may notify us of the change by calling our Member Services department at 1-800-868-2528. The change is effective the next day. The member should not seek medical attention from the new physician until the change becomes effective, unless there are special circumstances surrounding this event. If so, please call us. Please note that members also may change physicians via our Web site, www.BlueChoiceSC.com.

6.5 Specialty Care

When a member needs care from a specialist, the member's primary care physician and BlueChoice HealthPlan must authorize the visit. The primary care physician will complete a referral form and submit it to BlueChoice HealthPlan for approval.

The referral process is extremely important, so please remind your employees of these important points:

1. In most cases, only primary care physicians may refer. A specialist may not refer the member to another specialist, but he or she may refer the member to a hospital for diagnostic tests. Additionally, an OB/GYN may refer the member to contracting oncologists, radiation oncologists and surgeons for a member with a breast mass or other oncology diagnosis. However, the OB/GYN must contact BlueChoice HealthPlan for prior authorization.
2. The referral specialist must also be a member of the BlueChoice HealthPlan provider network. Please consult our provider directory or call Member Services to verify the specialist's status.
3. The member should present his or her BlueChoice HealthPlan ID card and referral form to the specialist or provider at the time of service.
4. Pay close attention to the number of visits and type of treatment the primary care physician has recommended. If the specialist recommends additional treatment or visits, the specialist will contact BlueChoice HealthPlan for a new referral.

Please note that the referral process does not apply to members using the out-of-network (self-referral) portion of BlueChoice Point of Service.

6.6 Prior Plan Approval

Some medical services require prior authorization from BlueChoice HealthPlan. Here are some examples:

- Inpatient and outpatient services.
- Magnetic resonance imaging (MRI).
- Physical, speech and occupational therapy.
- Durable medical equipment (wheelchairs, apnea monitors, glucose monitors, etc.).
- Home healthcare.
- Skilled nursing facilities.
- Sleep studies.

If a member is not sure when to seek prior plan approval, please encourage him or her to call our Member Services department at 1-800-868-2528 for assistance.

6.7 Emergency Care

We have developed guidelines for approving both emergency and urgent care claims. If members receive emergency or out-of-area urgent care from a non-participating facility or healthcare professional, we will review their claims carefully. The member may be responsible for payment if the claim doesn't meet these guidelines.

- If possible, the member should call a participating doctor or his or her primary care physician first. Remember, the primary care physician knows the member's medical history and is available 24 hours a day, seven days a week.
- If delaying medical care would make the member's condition dangerous, he or she should go to the nearest emergency facility. If the member can't make it to the hospital on his or her own, he or she should call 911 for assistance. If your area doesn't have 911 service, the member should dial "0" for the operator and state that it's an emergency.
- We consider a member's condition to be an emergency if the symptoms are severe, appear suddenly and need immediate medical attention. Examples of emergencies include:
 - Heart attacks
 - Strokes
 - Poisoning
 - Loss of consciousness
 - Inability to breathe
- Other conditions that meet medical criteria include those which are so severe that the average person with an average knowledge of health and medicine could reasonably expect if he or she does not get immediate medical attention, one of these conditions could occur:
 - Severe risk to one's health
 - Serious damage to body functions
 - Serious damage to any organs or body parts
- If a member has an emergency while traveling out of town, he or she should go to the nearest medical facility for treatment.
- The member should contact his or her primary care physician so that physician can coordinate all follow-up care.
- If the member is admitted to a hospital, the member should call the primary care physician and BlueChoice HealthPlan within 24 hours or the next working day. If the member is not able to call, a family member or friend should make the call.

6.8 Urgent Care

Sometimes, a member may not have an “emergency,” but also doesn’t think he or she can wait until normal office hours to seek care. When this happens, here are some things to remember:

- The member should call the primary care physician first. Remember, that physician knows the member’s medical history and is available 24 hours a day, seven days a week. Members also may seek care from a participating doctor.
- We consider a condition to require urgent care if it is not life threatening and is due to an unforeseen illness or injury. Examples include:
 - Deep cuts to the skin
 - Severe diarrhea without bleeding or dehydration
 - Ankle sprains
 - Earaches
 - Sore throats
 - Fevers
 - Acute sinusitis
 - Urinary burning, frequency or infection
- Examples of situations that we *do not consider* to require urgent care include:
 - Symptoms that have been present for 24 to 48 hours. Members should call their primary care physicians about these.
 - Routine follow-up care for chronic conditions, such as high blood pressure or diabetes
 - Drug refills
 - Removal of stitches
- If a member has an urgent care condition, his or her primary care physician may provide treatment, or recommend that the member see a participating specialist. Or, depending on the group contract, the member may go directly to one of our participating urgent care centers. Please consult our directories for a list of these centers.

If members travel outside our service area or are away at school, we’ll cover initial treatment of urgent care. They should call 1-800-446-6872 and ask for a referral to the nearest physician or urgent care center that will coordinate benefits with BlueChoice HealthPlan.

6.9 *Away From Home Care*® and Guest Membership

Extended out-of-town business. Kids away at school. Dependent children in another city. Anytime you or your family is away for at least 90 days, Members can become Guest Members at an affiliated BlueCross BlueShield health plan near your travel destination.

Just call BlueChoice HealthPlan before you leave and explain your situation. We'll find the health plan near your travel location, the host health plan, and have you complete a Guest Membership application. When you arrive at your destination, call the Host health plan's Away From Home Coordinator. He or she will give you important information, including a list of doctors and benefits available to you.

Here are the steps the member should take for guest membership:

1. Call BlueChoice HealthPlan's *Away From Home Care*® coordinator in our Member Services department at 1-800-868-2528 before leaving. The member should explain that he or she or a family member will be living away from home. We'll find the HMO near the travel destination and send the member a Guest Membership application to complete.
2. When the member arrives at the host HMO service area, he or she will receive information about the host HMO. It will include a list of physicians and benefits available to guest members.

6.10 BlueCard®

The suitcase picture on your member identification card indicates you have BlueCard® coverage, which provides coverage for followup and urgent care while traveling outside of South Carolina. For coordination of care, please contact the BlueCard® program at the number on the back of your ID card: 1-800-810-2583.

Follow Up Care

If you know you will need followup care while you're away from home and traveling outside of South Carolina, you should coordinate care with the BlueCard® program. Call BlueCard® at 1-800-810-2583. You'll receive the names and numbers of three network participants located near your travel area. You are responsible for scheduling an appointment.

Urgent Care

Whether you're away from home with an upset stomach or your child catches the flu, just call the BlueCard® program at 1-800-810-2583. A representative will find you three network participants located in your travel area. You are responsible for scheduling an appointment.

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

Please note that services are not available in all areas.

6.11 Health Management Programs — Great Expectations® for health

As a managed care organization, BlueChoice HealthPlan understands the importance of integrating health management and preventive services with other components of the healthcare delivery system to maintain the health of its members. As a result, we offer **Great Expectations® for health**, a set of health management programs that address a variety of health issues.

- Asthma
- Children's Health
- COPD
- Diabetes
- Depression
- Healthy Hearts
- Men's Health
- Migraine
- Pregnancy
- Smoking Cessation
- Weight Management
- Women's Health

Following is a summary of each health management program, including how members are enrolled, and who to contact for more information:

Asthma

Great Expectations® for asthma management is BlueChoice HealthPlan's education program for members with asthma. The program helps them learn how better to manage their asthma and improve quality of life. All members who have asthma are automatically enrolled in the program at **no charge**. Physicians may also refer members to the program.

The program consists of:

- Educational materials about asthma medications, asthma triggers and peak flow monitoring.
- Information about BlueChoice HealthPlan's coverage of asthma medicines and supplies.
- Newsletters and seasonal information about asthma and allergies.
- A free peak flow meter to members with chronic episodes.
- Information about asthma resources throughout the nation.
- Telephone counseling sessions with a registered respiratory therapist or health educator to help them better understand their asthma, asthma medications and asthma triggers (available to members with moderate to high risk asthma).
- Home health education visits to members with moderate to high risk asthma who need additional help managing and controlling their asthma.

For more information, please contact us at 1-800-327-3183, extension 25295.

Children's Health

Great Expectations® for children's health reminds parents of the importance of well-child check-ups and immunizations for their children. All children ages 2 and under are automatically enrolled at **no charge**. Deadly diseases such as polio and diphtheria are rarely seen, due to the implementation of vaccines for these diseases. However, these diseases could come back if children do not receive their immunizations or do not receive them in a timely manner.

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 of age. The cards list the immunizations needed at each age and encourage the parents to keep up with well-baby visits. The parents of children aged 12 also receive a reminder about the necessary vaccines for this age group.
- Brochures are provided to parents concerning newly recommended vaccines.
- The program is also a resource for any childhood health issue.

For more information, please contact us at 1-800-327-3183, extension 25289

COPD

Great Expectations® for Conquering the Obstacles of Pulmonary Disease is BlueChoice HealthPlan's education program for members with chronic obstructive pulmonary disease (COPD). The program helps them learn how better to manage their COPD and improve quality of life. All BlueChoice HealthPlan members who have COPD are enrolled at **no charge**, upon verification from the member or their physician.

The program consists of:

- Information about BlueChoice HealthPlan's coverage of COPD medicines and supplies.
- COPD newsletters and seasonal information.
- Telephone counseling sessions with a respiratory therapist or health educator to help them understand their COPD and identify lifestyle changes that will impact their COPD management.
- Home health educational visits by a respiratory therapist for members who need additional help in controlling their COPD.

For more information, please contact us at 1-800-327-3183, extension 25295.

Depression

Great Expectations® for depression management is designed to help members with depression understand their illness better. The program informs members about the importance of following their physician's recommendations for care, including taking medication, if prescribed, and keeping follow-up visits.

The program consists of:

- Information hand-outs and self-assessments, to help members learn more about depression. These are available, upon request from the member.
- Reminders to members whose doctor has advised them to take antidepressant medications for treating depression. These reminders include important information about taking medication for depression, including:
 - Use the medicine as directed.
 - Medication for depression may need to be taken for one to two
 - Months before an improvement is noticed.
 - The importance of taking the medication as instructed by the Physician, even if the member is feeling better.
- What to do if the member develops side effects from the medication.

For more information, please contact us at 1-800-327-3183, extension 25286.

Diabetes

Great Expectations® for diabetes control is BlueChoice HealthPlan's education program for members with diabetes. The program helps them learn how to manage their diabetes and reduce the risk of developing complications. All BlueChoice HealthPlan members who have diabetes are automatically enrolled at **no charge**. Physicians also may refer members to this program.

The program consists of:

- Educational materials about diet, exercise, medication, stress management and complications.
- Information about BlueChoice HealthPlan's coverage of diabetic medicines and supplies.
- Newsletters about new medications, diabetic treatments, nutritional guidelines, exercise strategies and other issues related to diabetes.
- Telephone counseling sessions with a registered dietitian, certified diabetes educator or health educator are available for members with questions. Also, members with particular risk factors such as an elevated HbA1c or with a recent hospitalization will be contacted by one of the program staff members.
- Diabetes education is available for any member who could benefit. This is available without an authorization and at no expense to the member. The diabetes education must be provided by an approved diabetes education center.

- Glucose monitors are available **free of charge**. Supplies such as test strips, lancets and syringes are covered as part of pharmacy benefits. A prescription for these items is needed from the member's physician. To request a free glucose monitor, call the number below.

For more information, please contact us at 1-800-327-3183, extension 25450.

Healthy Hearts

Great Expectations® for *healthy hearts* is BlueChoice HealthPlan's program for members who are at risk for or currently have heart disease. The program is designed to help members identify and improve risk factors for heart disease, specifically high blood cholesterol. All members who have heart disease, are on cholesterol medications and/or whose cholesterol is high according to national guidelines are automatically enrolled at **no charge**.

The program consists of:

- Educational materials about cholesterol, 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.

For more information, please contact us at 1-800-327-3183, extension 25289.

Men's Health

Great Expectations® for *men's health* is BlueChoice HealthPlan's program for men. The program is designed to remind men, aged 40 and older, of the importance of routine health screenings. Men who have not had at least one physician visit in the last year are sent a reminder letter encouraging them to make an appointment for a physical. The letter also outlines the screenings that are appropriate for men at various ages.

For more information, please contact us at 1-800-327-3183, extension 25289.

Migraine

Great Expectations® for *migraine management* is BlueChoice HealthPlan's program for members who suffer from severe, recurrent headaches. We provide information to members about the importance of having a personal physician to guide their headache management. This physician can help identify the best medications and dosing to decrease the frequency of headaches, control headache pain and improve quality of life.

The program consists of:

- Educational materials which help the member assess the severity and type of headaches they have. We also have helpful hand-outs to inform members about the variety of treatments available for migraine management. Members also get a copy of a headache diary which they can use to track their headache patterns to determine possible triggers.
- Assisting the member's physician by providing up-to-date information to improve continuity of care and treatment for that member's headaches.

For more information, please contact us at 1-800-327-3183, extension 25286.

Pregnancy

Great Expectations® for a healthy pregnancy helps members take steps towards a healthier pregnancy with educational materials and ongoing support and monitoring by our Great Expectations staff. A member is automatically enrolled in the program at **no charge** when her primary care physician or obstetrician sends in a maternity authorization form.

The program consists of:

- An maternity packet, including a detailed health assessment, that helps our staff assign the member a risk level of low, moderate or high. When the risk assessment is completed and returned, the member also receives a maternity book, **Your Pregnancy: Every Woman's Guide**.
- Members who are considered low risk will receive a mid-maternity phone call. Members who are determined to be moderate or high risk receive ongoing monitoring and phone calls from a maternity nurse case manager. Telephone counseling sessions address generic maternity information as well as the member's individual conditions. The maternity nurses also work with the high risk member and her physician to coordinate additional services as needed. All members are encouraged to call us anytime with questions or concerns they would like to discuss.
- Additional educational materials, as needed, on topics such as vegetarianism, twin gestation, pregnancy induced hypertension, etc. Members also receive additional materials through our Smoking Cessation and Gestational Diabetes Programs, when applicable.
- Referrals to external prenatal programs such as Sidelines of SC, WIC and other groups that may provide further assistance (financial, emotional, etc.).
- A phone call from our maternity staff after delivery to confirm that the member is recovering well in the transition from hospital to home.

For more information, please contact us at 1-800-327-3183, extension 25293.

Smoking Cessation

Great Expectations® for smokers only is designed to help members quit smoking with a five-week structured program that may be tailored to their needs. There is a \$15 fee for the program. However, the fee is waived for members participating in one of our other Great Expectations® programs, such as Asthma, COPD or Diabetes. Members may self-refer or be referred through their physician.

The program consists of:

- A comprehensive manual which covers the three phases of smoking cessation: Preparation, Skill Building and Relapse Prevention.
- Telephone counseling sessions with a health educator who provides support and information throughout the quitting process. The degree of support is tailored to the individual needs and preferences of the member.
- Clarification on member benefits for pharmaceutical interventions for smoking

cessation. While most members do not have this coverage through BlueChoice HealthPlan, we can provide information on the various methods a member may consider, upon request.

For more information, please contact us at 1-800-327-3183, extension 25286.

Weight Management

Great Expectations® for weight management is a 12-week program designed for members to learn about healthy eating and exercise behaviors, as well as behavior modification strategies to maximize weight loss and maintenance. The program is designed for members to work in a self-paced manner, though an introductory phone consultation with a health educator is offered to help members get started with the program and personalize it to their needs. The program costs \$5, to cover materials.

The program consists of:

- A comprehensive manual of materials, covering varied topics in weight management.
- The self-paced format includes various quizzes, self-assessments and log sheets to involve the member in the learning process.
- An initial phone consultation with a health educator to assist the member in beginning the program, setting goals, etc. Staff members are also available for follow-up questions throughout the program.

For more information, please contact us at 1-800-327-3183, extension 25286.

Women's Health

Great Expectations® for healthy women is BlueChoice HealthPlan's program for female members ages 20 and above. The program educates women 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. All female members automatically are enrolled at **no charge**.

The program consists of:

- Educational materials for new members, including information about the early detection of breast and cervical cancer, the management of menopause and other important health topics for women.
- Postcard reminders to women to encourage them to get their annual breast and cervical cancer screenings.
- Reminders for physicians concerning their patients that are due for yearly well-woman exams and screenings.
- Automatic referral program for members who are non-compliant with getting their annual mammograms.
- Promotion of mobile mammography through local hospitals for large employer groups.

Please contact us at 1-800-327-3183, extension 25289.