Focus on life. Focus on health. ***Stay focused.***

Administrative Guide

For administrative services only (ASO) groups with 51 or more employees

BlueChoice® HealthPlan
South Carolina

Table of Contents

Welcome!

Thank you for choosing BlueChoice HealthPlan as your carrier. This Employer Benefits Administration Guide for ASO groups with 51 or more employees will help you:

- Navigate your benefits.
- Understand all of your covered services.
- Understand the administrative operations in providing your health care benefits.

We hope this guide provides you with valuable information and assists you with key documentation and explanations of your contract.

We stay focused on helping you. **You should always contact your account management team if you have any questions that cannot be answered in this guide. If you can't reach a member of your account management team, please contact us in one of these ways:**

Email us:
BCHPLarge@BlueChoiceSC.com

Visit our website:
www.BlueChoiceSC.com

Call us Monday – Friday
from 8:30 a.m. – 5 p.m.:
866-280-0766, select option 2

We look forward to serving you and your employees — our valued customers — for years to come.

Section 1: Primary Contacts

1.1 Account Management Team

BlueChoice® prides itself on providing high levels of account and member service. We assign each of our groups to an account management team. Your account management team is responsible for managing your group from the group leader's perspective. You designate who your group leader will be. It may be the human resources or personnel contact or some other individual you designate as the liaison between you and the BlueChoice marketing staff.

Your account management team consists of an account executive, a service representative and Marketing Support Services (MSS) to answer any questions you may have or help you navigate any issues that arise.

Either your account executive or service representative can help you administer your plan. Both representatives have voicemail, so you can leave a message at any time. We require all BlueChoice representatives to return calls within 24 hours. Additionally, your account management team has an email address where you can send inquiries or correspondence.

ROLE	DUTIES	CONTACT INFORMATION
Account Executive	• Renewal execution and strategy • Client visits • Enrollment meetings • Wellness initiatives • Contract execution • Reporting and data analytics • Compliance coordination • Strategic Planning	**Name:** Nancy Roberts **Email:** Nancy.Roberts@BlueChoiceSC.com **Cell phone:** 803-361-6097 **Direct phone:** 803-382-5462 **Toll-free phone:** 800-327-3183, ext. 25462 **Fax:** 803-714-6461 (cover sheet necessary) **Street address:** 3060 Alpine Rd. AX-405, Columbia, SC 29223 **P.O. Box:** P.O. Box 6170, AX-405, Columbia, SC 29260
Service Representative	• Client visits • Enrollment meetings • Reporting and data analytics • Compliance coordination • Escalated questions and resolution • Pharmacy resolution • High-level day-to-day service	**Name:** Rhonda Swindler **Email:** Rhonda.Swindler@BlueChoiceSC.com **Cell phone:** 803-556-1782 **Direct phone:** 803-382-5592 **Toll-free phone:** 800-327-3183, ext. 25592 **Fax:** 803-714-6461 (cover sheet necessary) **Street address:** 3060 Alpine Rd. AX-405, Columbia, SC 29223 **P.O. Box:** P.O. Box 6170, AX-405, Columbia, SC 29260
Marketing Support Services	• Billing inquiries • Membership inquiries • Enrollment inquiries • Claims inquiries • Pharmacy inquiries • ID card requests • Requests for Explanation of Benefits (EOB), Summary of Benefits and Coverage (SBC) and letters of coverage	Monday – Friday, from 8:30 a.m. – 5 p.m. **Phone:** 866-280-0766, option 2 **Email:** BCHPLarge@BlueChoiceSC.com

1.2 Other Important Contacts To Remember

As you administer your employees' benefits, you may have questions. In addition to your account management team, these contacts may help you:

WHOM TO CONTACT	WHEN TO CONTACT US	HOW TO CONTACT US
Billing Questions	When you have questions about your bill	**Phone:** 866-569-5933, select option 3
Bill Payments	To pay your bill	**Visit:** www.QuickBillSC.com
Membership *(For update requests and applications only. No responses to inquiries.)*	To submit update requests and applications	**Email:** BCHPMembership@BlueChoiceSC.com
Member Services	To answer questions from covered employees	The phone number listed on the back of the members' ID cards

1.2.1 Member Advocates

BlueChoice's member advocates are available to answer your covered employees' questions and help them understand their benefits.

Phone: Your covered employees should call the phone number listed on the back of their member ID cards.
Hours: Monday – Friday, 8:30 a.m. – 5 p.m. EST (except holidays)

1.2.2 Voice Response Unit

BlueChoice has an automated voice response unit (VRU) available to your covered employees and their providers 24/7 year-round.

Your covered employees should call the phone number listed on the back of their member ID cards. They can check the following information through the automated system:

- Claims status
- Eligibility
- Benefits

Section 2: Benefits and Coverage

2.1 Contract

The Master Group Contract; Certificate of Coverage; Schedule of Benefits; Master Group Application; Membership Applications and attached amendments, addenda, riders or endorsements, if any, are considered the entire contract between BlueChoice and your employer. The contract cannot be modified, amended or changed in any manner whatsoever, except in writing and then signed by the chief operating officer of BlueChoice.

2.2 Summary of Benefits and Coverage

BlueChoice will comply with federal law by providing applicable Summaries of Benefits and Coverage (SBCs) to you. It is your responsibility to distribute the SBCs to your covered employees and dependents who live at a different address when it is known.

2.3 Exclusions and Limitations

Your contract outlines exclusions and limitations of services that will not be provided unless otherwise stated in the Schedule of Benefits. Treatment of an injury that is generally covered by this contract will not be denied if the injury results from an act of domestic violence or a medical condition, including both physical and mental conditions, even if the medical condition was not diagnosed before the injury.

2.4 Termination of Group Contract

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

1. **Nonpayment of premium.** The employer has failed to pay premiums or contributions in accordance with the terms of the contract or BlueChoice has not received timely premium payment. This contract, and all certificates issued thereunder, shall automatically terminate without notice on the 31st day following a premium due date unless BlueChoice receives the full premium at its home office no later than the 31st day after its due date. The effective date of the termination is retroactive to the premium due date. The contract shall continue in force during that 31-day period. The employer is liable for any claims paid during the 31-day period. We may charge you a fee if your premium is returned for nonsufficient funds (NSF). The NSF fee is $25.

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. It could also be intentional misrepresentation by the member or the member's representative. To the extent coverage is terminated and premiums are affected, premiums will be recalculated back to the date of the fraud or intentional misrepresentation.

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 can discontinue offering this particular type of coverage, provided BlueChoice:

      1) Gives notice of the discontinuation to each employer providing coverage under this insurance product, and the members covered under the coverage, of the discontinuation at least 90 days before the date of the discontinuation.

      2) Offers to each employer providing coverage under of this insurance product the option to purchase any other health insurance coverage currently being offered by BlueChoice to a group health plan in the large group market.

      3) Acts uniformly, without regard to the claims experience of those employers or any health status-related factor relating to any member covered or new member who may become eligible for coverage.

   B. BlueChoice can elect to discontinue offering all health insurance coverage in this state if:

      1) It provides notice of the discontinuation to the director of insurance and to each employer and member covered at least 180 days before the date of the discontinuation of coverage.

      2) All health insurance coverage issued or delivered in this state in such market is discontinued and coverage in the market is not renewed. BlueChoice cannot provide for the issuance of any health insurance coverage in the market in this state during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

2.5 Termination of Employee Contract

When a covered employee becomes ineligible for your group's health coverage, please complete a Membership Application and Change Form to terminate the employee's contract with BlueChoice. We must receive this form within 31 days of the qualifying event.

The Membership Application and Change Form should indicate the effective date of change and the reason for change (termination, death, conversion or COBRA applicant). If the covered employee is not available to sign the form, the group leader or personnel representative can sign.

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

2.6 COBRA Services

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires most employers with group health plans to offer employees the opportunity to temporarily continue their group health care coverage under their employer's plan if their coverage otherwise would cease due to termination, layoff or other change in employment status (referred to as qualifying events).

You can choose to outsource your COBRA administrative process through various vendors. Your account management team can help you with some questions. You may also have to contact your vendor directly.

2.6.1 Qualifying for COBRA

To qualify for COBRA, an employee must have a qualifying event, such as:

- The death of the covered employee.
- A covered employee's termination of employment or reduction of the hours of employment.
- Reduction in hours of the covered employee's employment.
- Divorce or legal separation of a covered employee from the employee's spouse.
- A covered employee becoming entitled to Medicare.
- A dependent child ceasing to be a dependent child of the covered employee under the generally applicable requirements of the plan and a loss of coverage occurs.

2.6.2 Notification Requirements When There Is a Qualifying Event

Separate requirements apply to the employer and the COBRA administrator. An employer that is subject to COBRA requirements must notify its group health plan administrator within 31 days after an employee's employment is terminated or employment hours are reduced. Within 14 days of that notification, the COBRA administrator must notify the individual of his or her COBRA rights. If the employer also is the plan administrator and issues COBRA notices directly, the employer has the entire 44-day period in which to issue a COBRA election notice.

2.6.3 COBRA Billing

Each month, BlueChoice will bill you for your COBRA participants (former employees) in addition to your regular invoice. We do not reach out to your former employees to collect payments. You or your COBRA administrator should reach out to your former employees to send them invoices and collect their payments.

Section 3: Accessing Medical Services

3.1 Getting Health Care Coverage

Advantage Plus is an open-access point-of-service plan. "Open access" means your covered employees have benefits when they visit any doctor they choose. "Point of service" means they decide at the time they need medical services whether to go to doctors within BlueChoice's statewide network or seek medical care outside the network.

3.1.1 Navigating the Networks

In Network

Many services, like preventive care services, routine health screenings, and well-baby and well-child care, are only covered when your covered employees receive care from in-network providers. While your covered employees don't need to select primary care physicians, we encourage them to do so to establish relationships with their doctors and have help coordinating their health care.

Benefits for other covered services are available at a higher level of coverage when your covered employees stay in the network. For this higher level of coverage, your covered employees simply visit participating physicians, hospitals and other network providers.

There are other advantages to using in-network providers. These providers file claims for covered expenses on behalf of your covered employees. Your covered employees pay only the copayments, deductibles and coinsurance amounts, if any, for covered expenses. Network doctors accept our payment as payment in full for covered expenses, minus the out-of-pocket expense, if any.

To find a network provider, your covered employees can visit www.BlueChoiceSC.com/findcare.

Out of Network

With Advantage Plus, your covered employees 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 your covered employees may have to pay higher copayments, deductibles and coinsurance, and they may have to file their own claims. Some services, such as preventive care services, will not be covered if your covered employees go outside the network. Please see your Schedule of Benefits for more information about covered services. Out-of-network providers may also bill your covered employees any balance over the BlueChoice allowed amount, except where prohibited by applicable law.

Special Out-of-Network Rules

If you get treatment from an out-of-network provider as described below, your treatment may be covered under the same terms as if the treatment had been received from an in-network provider, and the allowed amount will be the recognized amount. This exception applies only if certain situations apply. You will still be liable for any in-network cost share amounts under all other terms of this coverage. These are the only circumstances in which BlueChoice will allow for out-of-network services without authorization and approval:

- You are treated in the emergency department of a hospital or a free-standing emergency department where the facility or a treating provider is not in network, including post-stabilization services provided as part of outpatient observation or an inpatient or outpatient stay with respect to the emergency department visit where emergency services were furnished. In emergency situations, no prior authorization is required. For post-stabilization services, the provider or facility may furnish you a notice of treatment by a non-network provider and an opportunity to consent to the treatment, in which case this section will not apply to those post-stabilization services.
- You seek nonemergency treatment at an in-network hospital, hospital outpatient department, critical access hospital or ambulatory surgical center, but during your treatment, you get services from a non-network provider. An example of this would be if you have surgery performed in a network hospital and your surgeon is in network but the anesthesiologist is out of network. Except for certain ancillary services, and other items and services furnished due to unforeseen, urgent medical needs, the provider may furnish you a notice of treatment by a non-network provider and an opportunity to consent to the treatment, in which case this section will not apply to those services.
- It is medically necessary for you to be transported by an air ambulance company not in our network.

If you need assistance because one of the above actions has occurred, please contact us using the information on the back of your ID card.

3.2 BlueCard/Out-of-State Access

The suitcase icon on the member ID card indicates your covered employees have BlueCard coverage, which provides coverage for follow-up and urgent care while they travel outside of South Carolina. For coordination of care, your covered employees can contact the BlueCard program at 800-810-2583.

3.2.1 Follow-Up Care

If your covered employees know they will need follow-up care while they are away from home and traveling outside of South Carolina, they should coordinate care with the BlueCard program by calling 800-810-2583. They will receive the names and numbers of three network participants located near their travel area. They are responsible for scheduling an appointment.

3.3 Prior Authorization

The following items require prior authorization for any benefits to be covered:

- All inpatient admissions, except for emergency admissions
  For emergency admissions, you or someone acting on your behalf must notify BlueChoice no later than 24 hours after the admission or the next working day, whichever is later.
- Continued inpatient admissions
- Outpatient facility admissions, except for emergency admissions
  For emergency admissions, you or someone acting on your behalf must notify BlueChoice no later than 24 hours after the admission or the next working day, whichever is later.
- All inpatient, outpatient/office psychological testing, intensive outpatient and/or partial hospitalization programs, repetitive transcranial magnetic stimulation (rTMS) and electroconvulsive therapy, and certain prescription drugs for behavioral health disorders
- Prior authorization requests and treatment plans must be approved by Companion Benefit Alternatives (CBA), a separate company that assists in management of behavioral health and substance abuse benefits on behalf of BlueChoice.
- Autism spectrum disorder treatment
  Prior authorization requests and treatment plans must be approved by CBA.
- Dental services to sound natural teeth related to accidental injury after initial visit
- Habilitation services
- Home health services
- Hospice services
- Covered transplants, which must be obtained from a provider with a Blue Distinction Center for Transplant designation
- Durable medical equipment (DME) that has a purchase price or rental cost of $500 or more
  Any supplies used with DME must be authorized every 90 days.
- Virtual colonoscopies, subject to medical management guidelines
- Treatment of varicose veins
- Services, supplies or charges for a covered multidisciplinary pain management program, regardless of the state of location of the provider
- Prescription drugs as listed in the Prescription Drug List
- Cardiac rehabilitation
- Pulmonary rehabilitation
- Dialysis
- Radiation oncology
- Injectable/infusible chemotherapy
- Treatment of hemophilia
- Advanced radiology

- Nuclear cardiology
- Musculoskeletal care
- Home infusion therapy
- Home occupational therapy
- Home physical therapy
- Home speech therapy
- Biofeedback

If your covered employees are not sure when to seek prior plan approval, please encourage them to consult with their providers. Or employees can call the Member Services department at the phone number listed on the back of their member ID cards.

3.4 Emergency Care

We have developed guidelines for approving both emergency and urgent care claims. If your covered employees receive emergency or out-of-area urgent care from a nonparticipating facility or health care professional, we will review their claims carefully. Your covered employees may be responsible for payment if the claims don't meet these guidelines.

- If possible, a covered employee should call a participating doctor or his or her primary care physician first. Remember, the primary care physician knows your covered employee's medical history and is available 24/7.
- If delaying medical care would make your covered employee's condition dangerous, he or she should go to the nearest emergency facility. If a covered employee 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 services, your covered employee should dial "0" for the operator and state that it's an emergency.
- We consider your covered employee's condition to be an emergency if the symptoms are severe, appear suddenly and need immediate medical attention. Examples of emergencies include the following:
  - Heart attacks
  - Strokes
  - Poisoning
  - Loss of consciousness
  - Inability to breathe
- Other conditions that meet medical criteria include those that are so severe that a 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 covered employee has an emergency while traveling out of town, he or she should go to the nearest medical facility for treatment.
- Your covered employee should contact his or her primary care physician so the physician can coordinate all follow-up care.
- If your covered employee is admitted to a hospital, he or she should call the primary care physician and BlueChoice within 24 hours or the next working day. If your covered employee is not able to call, a family member or friend should make the call.

3.5 Ambulance Services

Professional ambulance services to a local hospital in the United States are covered in connection with an acute injury or an emergency medical condition. Coverage is also provided in connection with an interfacility transport between acute care facilities in the United States when medically necessary for a higher level of services. No benefits are provided for international ambulance services or ambulance services used for routine, nonemergency transportation, including but not limited to travel to a facility for scheduled medical or surgical treatments, such as dialysis or cancer treatment or transfer to a subacute place of care, such as a skilled nursing facility. All claims for ambulance services are subject to review for medical necessity. The allowed amount for ambulance services provided by nonparticipating providers will be determined in accordance with the applicable fee schedule.

Air Ambulance Transportation

Authorization is required for transportation as an inpatient from one hospital to a second hospital using an air ambulance. All of these requirements must be met:

- The first hospital does not have needed hospital or skilled nursing care for the member's illness or injury, such as burn care, cardiac care, trauma care and critical care.
- The second hospital is the nearest medically appropriate facility.
- A ground ambulance transport endangers the member's medical condition. The transport is not related to a hospitalization outside the United States.

Cost sharing requirements for covered out-of-network air ambulance services are described in the section that explains out-of-network coverage.

3.6 Urgent Care

Sometimes your covered employee 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:

- Your covered employee should call his or her primary care physician first. Remember, the physician knows your covered employee's medical history and is available 24/7. Your covered employee can also 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 the following:
  - 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 we do not consider to require urgent care include:
  - Symptoms that have been present for 24 to 48 hours. Your covered employee should call his or her primary care physician about these.
  - Routine follow-up care for chronic conditions, such as high blood pressure or diabetes.
  - Drug refills.
  - Removal of stitches.

- If your covered employee has an urgent care condition, his or her primary care physician can provide treatment or recommend that your covered employee see a participating specialist. Or, your covered employee can go directly to one of our participating urgent care centers.

Please visit www.BlueChoiceSC.com/findcare for a list of these centers.

If your covered employee travels outside our service area or is away at school, we'll cover initial treatment of urgent care. To find the nearest physician or urgent care center that will coordinate benefits with BlueChoice, he or she can visit www.BlueChoiceSC.com/findcare.

3.7 Pharmacy Benefits

We provide coverage for prescription medication unless it is specifically excluded in the contract. If it is a covered service, your covered employees should have their drugs prescribed by participating physicians and should purchase them at participating pharmacies. Benefits for covered prescription medications dispensed to your covered employees should not exceed the quantity and benefit maximum, if applicable, as specified.

View participating pharmacies at www.BlueChoiceSC.com.

We provide benefits only for the most cost-effective prescription medication available at the time dispensed, whenever medically appropriate, and in accordance with all legal and ethical standards. Certain prescription medications require prior authorization and/or step therapy to be covered and have quantity limits as determined by BlueChoice.

The BlueChoice Prescription Drug List includes drugs on different tiers, each with its own copayment and/or coinsurance levels. We choose drugs for each level based on their value, which takes into consideration how well they work and their cost.

For information about prescription medications, please refer to the Prescription Drug List.

Before enrollment, your covered employees can view the Prescription Drug List at www.BlueChoiceSC.com.

After enrollment, your covered employees can get personalized information by:

- Logging in to **My Health Toolkit**.
- Selecting **Pharmacy Benefits** under the **Benefits** tab.

The Prescription Drug List shows the coverage levels, called tiers, for most covered drugs. Each tier has its own copayment and/or coinsurance levels. Once your covered employee has identified the tier that is applicable to his or her prescription medication, he or she can refer to the Schedule of Benefits to determine how much he or she will pay for a prescription medication based on its tier. A list of any drugs that are not covered (i.e., excluded) by this plan can also be found on the BlueChoice website.

For fully insured accounts, if a participating physician prescribes a nongeneric drug and there is a less expensive equivalent available, your covered employees will be responsible for paying the difference between the two drugs in addition to their normal copayments or coinsurance. For self-insured accounts, your pharmacy benefits may vary based on the terms of your contract.

3.8 Retail Health Clinic

Your covered employees can visit any CVS Minute Clinic for the same price as primary care physician visits. CVS is an independent company that provides pharmacy benefits on behalf of BlueChoice. Your covered employees can go to a Minute Clinic for:

- Minor illnesses like colds, sore and strep throat, sinus infections, bronchitis, earaches, ear infections, flu, mouth pain, nausea, vomiting, and diarrhea.
- Minor injuries like blisters, bug bites and stings, tick bites, minor burns, cuts, splinter removal, sprains, strains and joint pain, and suture and staple removal.
- Screenings like basic health screenings for cholesterol, diabetes and hepatitis C; A1C checks; and blood pressure monitoring.
- Vaccinations and injections.
- Wellness and physicals.
- Travel health.
- Women's services, like birth control care, birth control injections, HPV vaccines, pregnancy evaluation, and treatment for urinary tract and bladder infections.

3.9 Blue CareOnDemand*

Blue CareOnDemand is a fast, easy way for your covered employees to see doctors. Your covered employees can visit with doctors via smartphones, tablets or computers rather than visiting offices or urgent care facilities. Doctors will diagnose and write prescriptions as appropriate.

Services Available With Blue CareOnDemand

Urgent Care: Skip the waiting room for common issues such as cold and flu symptoms, sinus infections, ear infections, and more.

Behavioral Health: Schedule an appointment with a mental health professional to help with life's challenges.

Breastfeeding Support: Meet with a lactation consultant for common questions and issues associated with breastfeeding.

Get Started Now

There are two easy ways for your employees to use Blue CareOnDemand:

- From a mobile phone or tablet, they can download the Blue CareOnDemand app for an Apple or Android device.
- From a computer, they can go to www.BlueCareOnDemandSC.com.

Please note, this service is only for applicable employer groups and members. Your employees may call the Member Services number located on the back of their member ID cards to confirm if this service is available to them. Or you may contact your marketing representative to confirm if this benefit is available to your employer group.

*Members enrolled in high-deductible health plans must meet any deductible and coinsurance requirements.

3.10 Transition of Care/Continuation of Care

If benefits are no longer covered for a provider due to a change in the provider's terms of participation in the network, you may be eligible to get network benefits for that provider's services for a limited period of time. Examples of this happening include when a network provider's contract with BlueChoice or CBA is modified, ends or is not renewed for any reason other than fraud or failure to meet specified quality standards, including suspension or revocation of the provider's license. Another example is when the contract is terminated and you are a continuing care patient of the provider at the time.

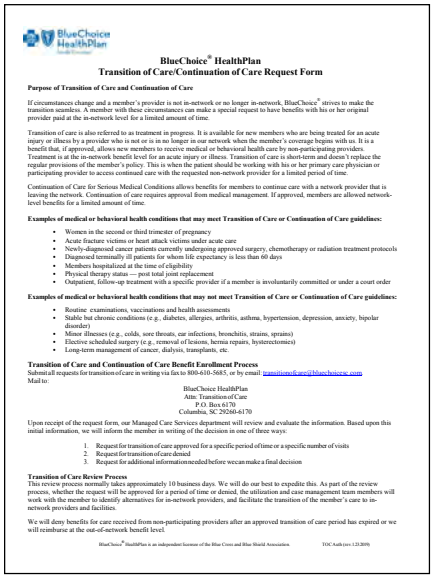
We will attempt to notify you if and when these situations arise with your providers and explain your right to elect continued network coverage, but such continued network coverage is not automatic. Please contact us or have your provider contact us to get continued network coverage.

We recommend you use a form for this request. You can find this form on the website at www.BlueChoiceSC.com. You can also call the Member Services phone number on your BlueChoice ID card. Your treating physician should include a statement on the form confirming that you have a serious medical condition. When we get your request, we will confirm the last date the provider is part of our network and a summary of requirements for continuation of care. If we need more information, we may contact you or the provider.

If you qualify for continued in-network status, we will provide in-network benefits for you from that provider, for the course of treatment relating to your status as a continuing care patient, for 90 days or until the date you are no longer a continuing care patient with respect to the provider, whichever occurs earlier. Such continued network status is subject to all other terms and conditions of the contract, including regular benefit limits.

Transition of care is also referred to as treatment in progress. It is available for a new covered employee who is being treated for an acute injury or illness by a provider who is not in our network when his or her coverage begins with us. It is a benefit that, if approved, allows your new covered employee and covered dependents to receive medical or behavioral health care by nonparticipating providers.

Treatment is at the in-network benefit level for an acute injury or illness. Transition of care is short term and doesn't replace the regular provisions of the program. This is when the patient should be working with his or her primary care physician or participating provider to access continued, ongoing care through BlueChoice.



BlueChoice® HealthPlan
Transition of Care/Continuation of Care Request Form

Purpose of Transition of Care and Continuation of Care

If circumstances change and a member's provider is not in-network or no longer in-network, BlueChoice® strives to make the transition seamless. A member with these circumstances can make a special request to have benefits with his or her original provider paid at the in-network level for a limited amount of time.

Transition of care is also referred to as treatment in progress. It is available for new members who are being treated for an acute injury or illness by a provider who is not or is in no longer in our network when the member's coverage begins with us. It is a benefit that, if approved, allows new members to receive medical or behavioral health care by non-participating providers. Treatment is at the in-network benefit level for an acute injury or illness. Transition of care is short-term and doesn't replace the regular provisions of the member's policy. This is when the patient should be working with his or her primary care physician or participating provider to access continued care with the requested non-network provider for a limited period of time.

Continuation of Care for Serious Medical Conditions allows benefits for members to continue care with a network provider that is leaving the network. Continuation of care requires approval from medical management. If approved, members are allowed network-level benefits for a limited amount of time.

Examples of medical or behavioral health conditions that may meet Transition of Care or Continuation of Care guidelines:

- Women in the second or third trimester of pregnancy
- Acute fracture victims or heart attack victims under acute care
- Newly-diagnosed cancer patients currently undergoing approved surgery, chemotherapy or radiation treatment protocols
- Diagnosed terminally ill patients for whom life expectancy is less than 60 days
- Members hospitalized at the time of eligibility
- Physical therapy status — post total joint replacement
- Outpatient, follow-up treatment with a specific provider if a member is involuntarily committed or under a court order

Examples of medical or behavioral health conditions that may not meet Transition of Care or Continuation of Care guidelines:

- Routine examinations, vaccinations and health assessments
- Stable but chronic conditions (e.g., diabetes, allergies, arthritis, asthma, hypertension, depression, anxiety, bipolar disorder)
- Minor illnesses (e.g., colds, sore throats, ear infections, bronchitis, strains, sprains)
- Elective scheduled surgery (e.g., removal of lesions, hernia repairs, hysterectomies)
- Long-term management of cancer, dialysis, transplants, etc.

Transition of Care and Continuation of Care Benefit Enrollment Process

Submit all requests for transition of care in writing via fax to 800-610-5685, or by email transitionofcare@bluechoicesc.com

Mail to:

BlueChoice HealthPlan
Attn: Transition of Care
P.O. Box 6170
Columbia, SC 29260-6170

Upon receipt of the request form, our Managed Care Services department will review and evaluate the information. Based upon this initial information, we will inform the member in writing of the decision in one of three ways:

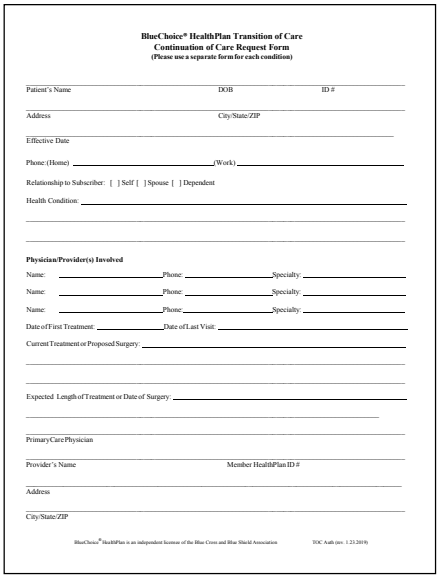
1. Request for transition of care approved for a specific period of time or a specific number of visits
2. Request for transition of care denied
3. Request for additional information needed before we can make a final decision

Transition of Care Review Process

This review process normally takes approximately 10 business days. We will do our best to expedite this. As part of the review process, whether the request will be approved for a period of time or denied, the utilization and case management team members will work with the member to identify alternatives for in-network providers, and facilitate the transition of the member's care to in-network providers and facilities.

We will deny benefits for care received from non-participating providers after an approved transition of care period has expired or we will reimburse at the out-of-network benefit level.

BlueChoice® HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association. TOC Auth (rev. 1.23.2019)



BlueChoice® HealthPlan Transition of Care
Continuation of Care Request Form
(Please use a separate form for each condition)

Patient's Name DOB ID #

Address City/State/ZIP

Effective Date

Phone: (Home) (Work)

Relationship to Subscriber: [ ] Self [ ] Spouse [ ] Dependent

Health Condition:

Physician/Provider(s) Involved

Name: Phone: Specialty:

Name: Phone: Specialty:

Name: Phone: Specialty:

Date of First Treatment: Date of Last Visit:

Current Treatment or Proposed Surgery:

Expected Length of Treatment or Date of Surgery:

Primary Care Physician

Provider's Name Member HealthPlan ID #

Address

City/State/ZIP

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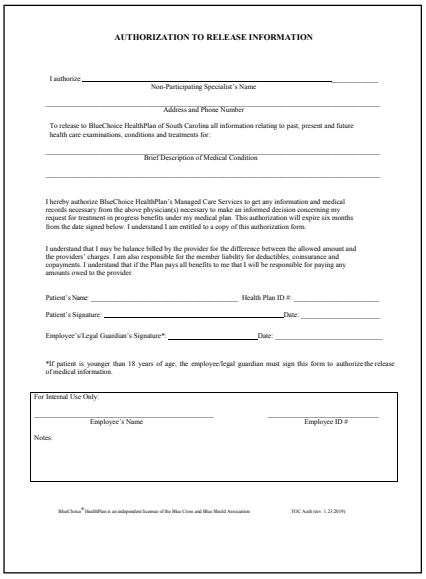


AUTHORIZATION TO RELEASE INFORMATION

I authorize
Non-Participating Specialist's Name

Address and Phone Number

To release to BlueChoice HealthPlan of South Carolina all information relating to past, present and future health care examinations, conditions and treatments for:

Brief Description of Medical Condition

I hereby authorize BlueChoice HealthPlan's Managed Care Services to get any information and medical records necessary from the above physician(s) necessary to make an informed decision concerning my request for treatment in progress benefits under my medical plan. This authorization will expire six months from the date signed below. I understand I am entitled to a copy of this authorization form.

I understand that I may be balance billed by the provider for the difference between the allowed amount and the providers' charges. I am also responsible for the member liability for deductibles, coinsurance and copayments. I understand that if the Plan pays all benefits to me that I will be responsible for paying any amounts owed to the provider.

Patient's Name: Health Plan ID #:

Patient's Signature: Date:

Employee's/Legal Guardian's Signature*: Date:

*If patient is younger than 18 years of age, the employee/legal guardian must sign this form to authorize the release of medical information.

For Internal Use Only:

Employee's Name Employee ID #

Notes:

BlueChoice® HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association TOC Auth (rev. 1.23.2019)

If your covered employee needs a Transition of Care/Continuation of Care Form, he or she can find one at www.BlueChoiceSC.com by selecting the **Find a Form** link on the homepage. Your covered employee must complete the authorization to release information, which is part of the form.

3.11 Authorization To Disclose Protected Health Information

BlueChoice is committed to protecting your covered employees' confidential health information. We are not allowed to give your covered employees' protected health information to another person unless we have legal permission. What does this mean? If your covered employees want to let their spouses, family members or close friends contact us for their claims or payment information, we can't release it unless they have given us permission. They must give us their permission in writing.

Your covered employees can complete an Authorization To Disclose Protected Health Information form. They can use this form to give us permission to release information to someone else. They don't have to complete and return this form unless they want someone other than themselves to receive their protected health information. Please note that parents of a minor child (under the age of 16) can still get information about their child without having to complete this form.

To get the form, they can visit www.BlueChoiceSC.com and select the **Find a Form** link on the homepage.

Section 4: Membership Enrollment and Changes

4.1 Paper Enrollment

Eligible new employees and their covered dependents can elect BlueChoice coverage. Coverage begins when the employee becomes eligible for your company's health benefits and eligibility is received by BlueChoice. You should submit a Membership Application and 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 can submit the form 31 days in advance of the effective date of coverage. The 31-day deadline also applies when making changes for a current covered employee as a result of a qualifying event.

BlueChoice HealthPlan
South Carolina

MEMBERSHIP APPLICATION AND CHANGE FORM

REQUIRED EMPLOYEE INFORMATION (Please Print)

1. Name (Last, First, MI):_____ 2. Birthdate:____/____/____ 3. Male ☐ Female ☐
4. Address (Street):_____ (City):_____ (State):_____ (ZIP):_____
5. Employee Social Security Number (Required):_____ 6. Phone (Required): (___)_____Cellphone: ☐ Yes ☐ No
7. Email (Required):_____ 8. Name of Employer:_____
9. Effective Date of Action Requested:____/____/____ 10. Tobacco Use* (small group only): ☐ Yes ☐ No

REASON FOR APPLICATION

11. ☐ New Member – Full-Time Employee; Full-Time Date of Hire:____/____/____
☐ Coverage Change – Reason for Change:_____ Date of Occurrence:____/____/____
☐ Cancellation – Date Left Employment:____/____/____
☐ Reinstatement – Reason: ☐ Return from Layoff ☐ Return from Leave
☐ COBRA/State Continuation: Start Date:____/____/____
12. Group Number (if known for changes to existing plan):_____

COVERAGE INFORMATION 13. Plan Choice:_____

14. MEDICAL ELECTION
☐ Employee Only ☐ Employee/Spouse
☐ Employee/Child(ren) ☐ Family

☐ No Medical Coverage Due To (Check one):
☐ Other BlueChoice® Coverage (01)
☐ Covered by Military (03)
☐ Insurance with Another Company (02)
☐ Covered by Medicare (12)
☐ Covered by Spouse with this Employer (07)
☐ Other (05); Explain:_____

15. DENTAL ELECTION (if applicable)
☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren)
☐ Family ☐ No Dental Coverage

16. LIFE COVERAGE (if applicable) (underwritten by Companion Life)**
☐ Life Only (No Medical) ☐ Life and AD&D ☐ Dependent Life
☐ STD ☐ LTD ☐ No Life Coverage
Life Amount: $_____ Life Class:_____ **Earnings:** $_____
☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually

Beneficiary Designation *(All Plans – applicable only if life coverage is available and selected)*
Primary:_____ Relationship:_____
Contingent:_____ Relationship:_____

ENROLLMENT INFORMATION (List all individuals to be covered.)

17.	Last Name	First Name	Birthdate (mm/dd/yyyy)	Male or Female	Social Security Number	Other Insurance Yes	Other Insurance No	Tobacco Use * Yes	Tobacco Use * No
Spouse						☐	☐	☐	☐
Child						☐	☐	☐	☐
Child						☐	☐	☐	☐
Child						☐	☐	☐	☐
Child						☐	☐	☐	☐

*** Please indicate whether any person age 18 or older has used tobacco four or more times a week in the last six months.**

OTHER COVERAGE INFORMATION

18. If you or any of your family members have other health (including Medicare), dental or drug coverage other than with this employer, what is the name of the insurance company and the policyholder's ID number?_____

EMPLOYEE CERTIFICATION *Authorization to Release Information and Statement of Understanding*
I authorize release to BlueChoice HealthPlan or its representatives all past and future medical records for myself and eligible dependents and other information deemed necessary by BlueChoice to review, process or investigate claims. This authorization includes Medicare Parts A and B claims. I understand the benefits for which I (we) will be eligible are those disclosed in the group contract between the insurer and my employer. I also understand that my coverage may be voided or terminated, or claims denied, if fraud or intentional misrepresentations of material facts have been made on this application, subject to the Incontestability provision. The statements made herein are complete and true to the best of my knowledge.

BlueChoice HealthPlan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Signature:_____ **Date**:_____

BC-1019 (Rev. 5/2017) **Companion Life is a separate life insurance company that does not provide BlueChoice products or services. Companion Life is solely responsible.

Your service representative will supply you with enrollment materials, which may include:

- A BlueChoice brochure.
- The Summary of Benefits.
- Other forms as required.

You can find the Membership Application and Change Form online by visiting www.BlueChoiceSC.com and selecting the **Find a Form** link on the homepage.

Please review the form to make sure the employee provides complete information that is consistent with the information in your company records. As the group leader, you will need to insert your appropriate BlueChoice group and subgroup numbers.

You should check the appropriate box on the form — either New Member or Coverage Change with the corresponding reason — and fill in the effective date. The employee should complete the rest of the form.

The 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.

4.2 Electronic Data Interchange (EDI) Enrollment

If you use a payroll vendor or software to manage your benefit enrollment information, we can work with you to have that information sent to us automatically. Our service will translate your data and enter it into our system. It may take up to 60 days to implement the process due to setup and testing.

4.2.1 Setting Up EDI Enrollment

If you do not currently have EDI enrollment but would like to set it up, contact your account management team, and they will help you.

4.2.2 Changes, Additions or Cancellations of Your Covered Employees' Plans

If you have changes, additions or cancellations, you need to send all your transactions through your EDI enrollment vendor. If it is an emergency, contact a member of your account management team, and he or she will assist you.

4.3 Changes

No one, except new hires and new dependents acquired through a qualifying event, may join the plan outside the mutually agreed-upon enrollment period. BlueChoice conducts an annual open enrollment period for each employer, usually just before the effective date of coverage or renewal date. During this period, your employees and their dependents can elect our coverage. Your account management team 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.

4.3.1 Changes in Employment Status

Termination of Employment — BlueChoice's coverage ends at the end of the month following termination of employment or earlier, based on your company's policy. Retroactive terminations are acceptable if we receive it within 31 days of your covered employee's coverage termination and if your covered employee had no benefit payments during that period. If we paid benefits during such a period, **premiums are due and payable through the end of the month in which we provided benefits**.

Layoffs/Leaves of Absence — Your covered employee who is laid off or who has a leave of absence may be able to continue his or her BlueChoice coverage on a group/individual basis.

4.3.2 Changes in Family Status

Please notify BlueChoice of any changes in a family's status within 31 days of the qualifying event. You will use the Membership Application and Change Form or EDI to terminate a family member.

Please remember, the Membership Application and Change Form or EDI must contain the covered employee's name, address, Social Security number and requested effective date of termination. The covered employee or group leader should check the Coverage Change box and indicate the reason for termination (divorce, death or other).

The covered employee should list each dependent he or she wishes to disenroll in the enrollment information section (for example, spouse 02, first child 03, second child 04, etc.). The covered employee should include the dependent's full name, gender, Social Security number and date of birth.

4.4 Qualifying Events

BlueChoice recognizes these qualifying events as reasons to change status outside the open enrollment period:

- Birth
- Marriage/divorce
- Death
- Legal adoption
- Addition of stepchildren or foster children
- Reduction in the number of hours of employment or employer contributions toward coverage were terminated.
- Termination of employment
- Qualified medical child support order
- Termination of Medicaid or the Children's Health Insurance Program (CHIP) coverage or eligibility for premium assistance under Medicaid or CHIP

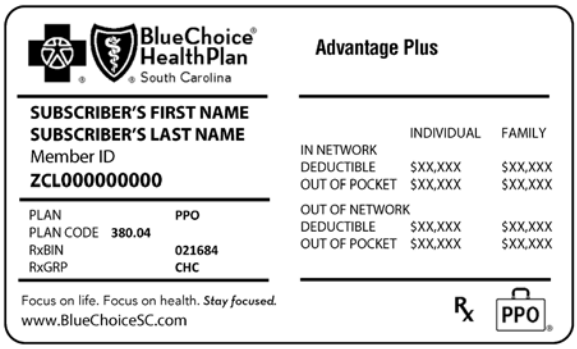
Please use the Membership Application and Change Form or EDI to notify BlueChoice of any change in employment status or family situation that may affect BlueChoice coverage. Our Membership department must receive this form within 31 days of the qualifying event. We must receive premiums before coverage will become effective. We do not accept additions, deletions or changes outside this 31-day period.

4.5 ID Cards

Once we have processed enrollment for your covered employees, they will receive their member ID cards in the mail. If your covered employees lose their ID cards, they can always access their digital ID cards and request a new copy through My Health Toolkit, our secure online portal, at www.BlueChoiceSC.com. (See page 31 for more details.)

When a covered employee receives his or her member ID card, he or she should verify all information on the front of the card and carefully read the information on the back. Please note that the card will only have the subscriber's name on it. Your covered employees should carry their cards with them at all times and present them whenever they receive medical services or prescription drugs.

Sample ID Card



Note: For those employers with customized member ID cards, information on your cards may be different than that shown above.

4.5.1 Digital Member ID Cards

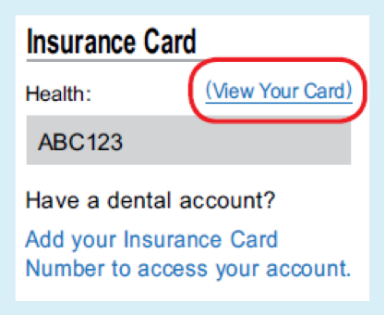
Your employees can access their digital member ID cards anytime, anywhere from their computers or mobile devices.

Advantages of the Digital ID Card

The digital member ID card is identical to the physical card. It contains the member ID number and other coverage details unique to the member. Unlike the physical card, your employee doesn't have to worry about losing it or ordering duplicate copies for his or her family. Your employee can easily:

- View the card on a smartphone, tablet or computer.
- Email the card to a spouse, child, doctor's office or pharmacy.
- Print the card at home from a smartphone, tablet or computer.

Your employee can use the printed card just like a physical card.



How your employee can access his or her ID card

- On mobile devices: The employee can access the digital ID card through the My Health Toolkit app (see page 34).
- On computers: He or she can go to www.BlueChoiceSC.com and log in to My Health Toolkit. In the **Insurance Card** section on the left, the employee should select **View Your Card**.

If your covered employee does not have a My Health Toolkit account and does not know his or her member ID card number, he or she can:

- Enter the subscriber's Social Security number.
- Enter his or her date of birth.

For complete instructions on how to sign up for a My Health Toolkit account, see Section 7.2.1. Your employee should not discard the physical member ID card. Some doctors may still want a copy of it for their records.

4.6 Verification of Coverage Letter

Sometimes you may have a covered employee who signs up for coverage and needs to see a provider immediately. In this scenario, the covered employee won't have a member ID card to present to the provider as proof of coverage. We can email you a letter with your covered employee's information, which he or she can use with the provider. Simply contact your account management team, and they can get the letter for you.

4.7 Non-COBRA Eligible Employees

Your covered employees without COBRA options who continue to live in the BlueChoice service area may be able to convert to individual policies. Your covered employees cannot have had any lapse in coverage or been terminated for nonpayment of premiums before conversion. The new individual policy will be one that complies with Affordable Care Act provisions.

To continue benefits, we must receive the Membership Application and Change Form indicating conversion within 31 days of the loss of coverage.

4.8 Retro Terminations

BlueChoice agrees to a 60-day period of retroactive premium adjustments. **We will not honor this period if benefit coverage has been used.** BlueChoice will not agree to accept retroactive premium payments and apply coverage back to the date of hire or date of eligibility if the time period is more than 60 days.

4.9 Age 26 Dependent Terminations

It is the policy of BlueChoice to terminate over-age dependents when they reach the maximum dependent age, based on the limits set by your contract.

If a dependent qualifies as incapacitated, please have your covered employee complete the Request for Benefit Extension for an Incapacitated Dependent. The covered employee can find the form by visiting www.BlueChoiceSC.com and selecting **Find a Form** on the homepage. Return the completed form to BlueChoice following the instructions at the top of the form.

Upon receipt of this information, BlueChoice will review. To ensure the dependent meets BlueChoice's criteria of an incapacitated dependent, please refer to the Certificate of Coverage or benefit materials for a definition of incapacitated dependent.

Focus on life. Focus on health. *Stay focused.*

Section 5: *Quick*Bill

5.1 What Is *Quick*Bill?

*Quick*Bill is BlueChoice's secure online billing system. *Quick*Bill makes managing monthly invoices efficient, convenient and easier than ever. The *Quick*Bill application lets you monitor monthly group billing information, run various payment reports and make online premium payments. You can also generate membership and enrollment reports through *Quick*Enroll.

5.2 How To Access *Quick*Bill

We will email groups the initial invoice. The cover letter contains the group's username and password for *Quick*Bill.

To access *Quick*Bill, the group representative should:

- Go to www.QuickBillSC.com.
- Enter the username and password to log in to the group's account. If he or she forgets the username or password, he or she can email QuickBill.Setup@BlueChoiceSC.com.

5.3 How To Read and Pay a Bill

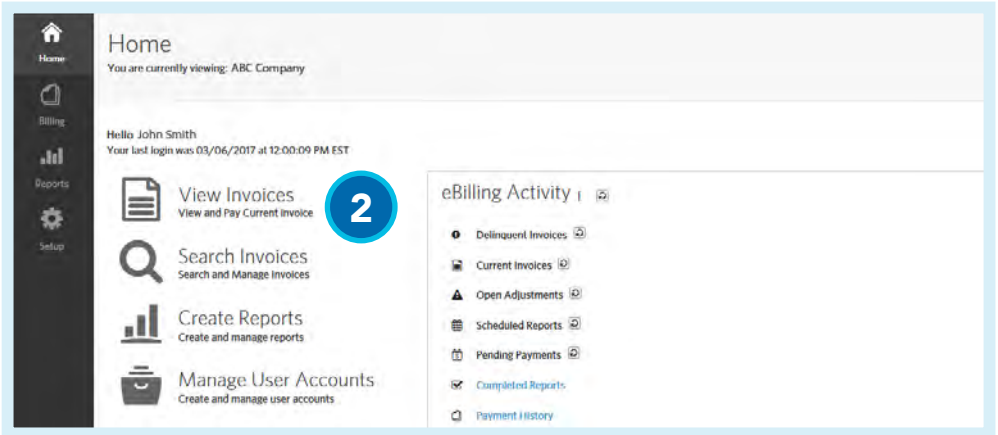
Premium payments for coverage are due on a prepaid basis. You will receive an email notification each month stating your invoice is ready to view on *Quick*Bill. BlueChoice mails premium invoices before the first of the month in which the premium is due. We apply payments to the oldest balance.

Step 1:

- Go to www.QuickBillSC.com.
- Enter your username and password to log in to your account. If you forget your username and password, you can email QuickBill.Setup@BlueChoiceSC.com.

Step 2:

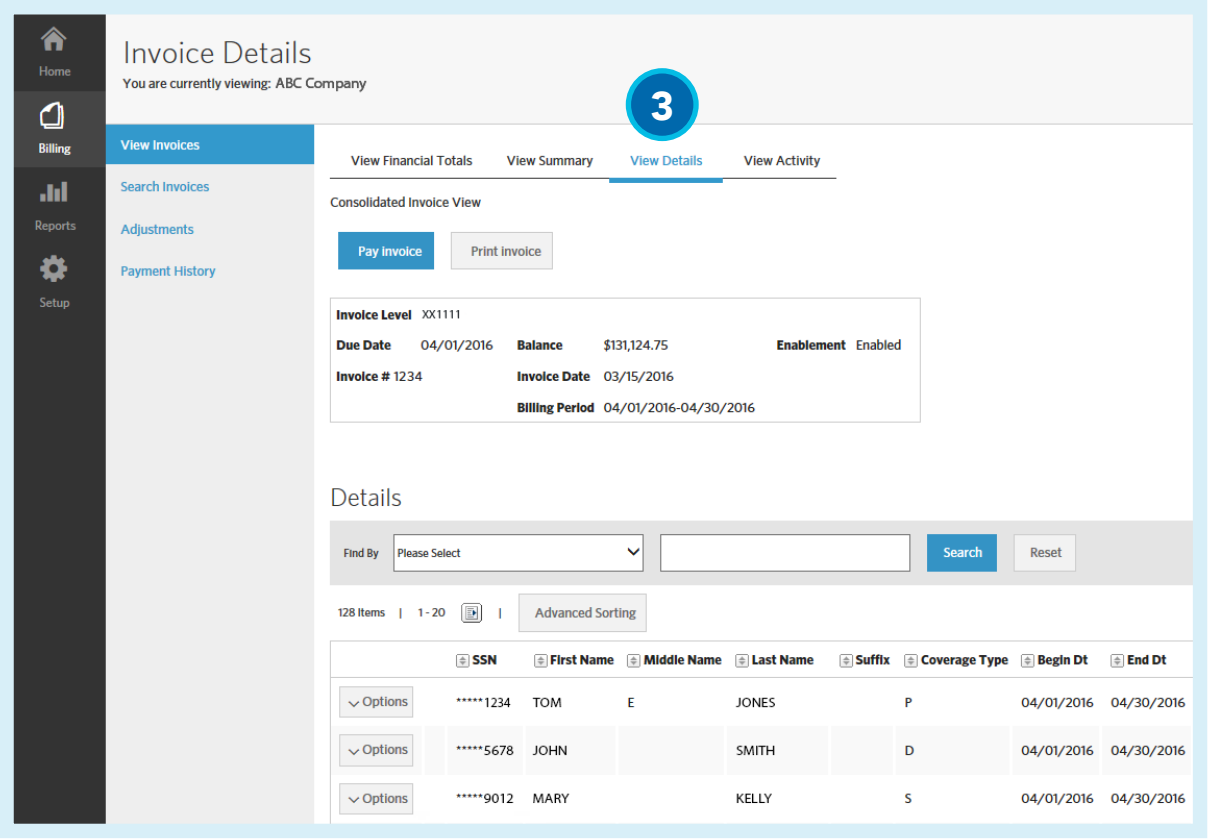
To view your invoices or make an electronic payment, select **View Invoices**.



SECTION 5

Step 3:

To view the details of your bill, including your roster of covered employees, select **View Details**.



Step 4:

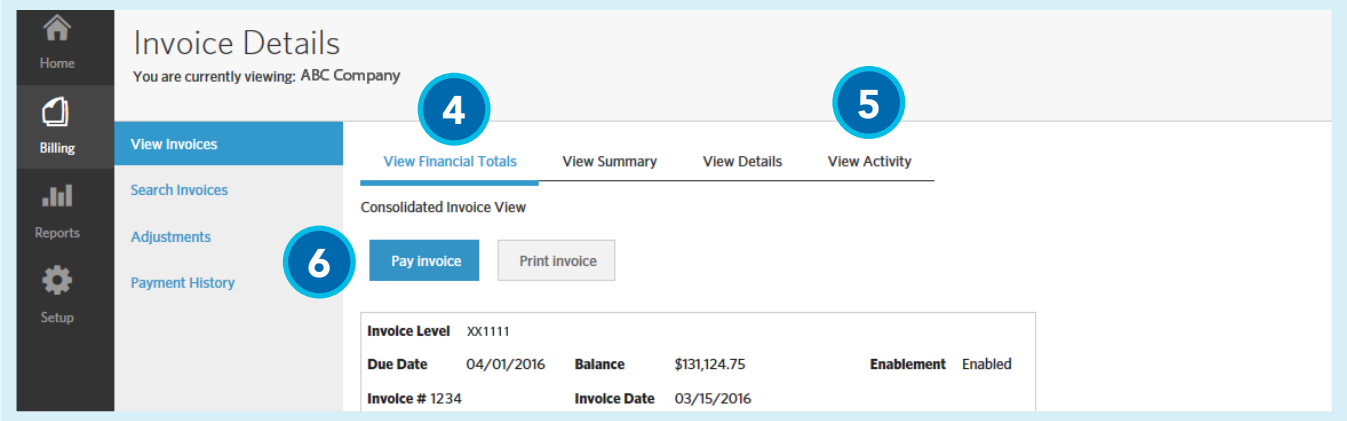
Choose **View Financial Totals** to view the line items of your bill.

Step 5:

Select **View Activity** to see employees who have added, changed or terminated coverage.

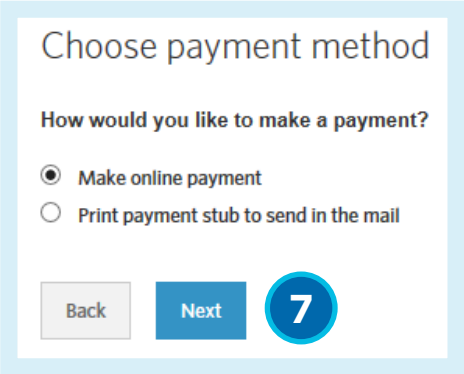
Step 6:

To pay your invoice, choose **Pay Invoice**.



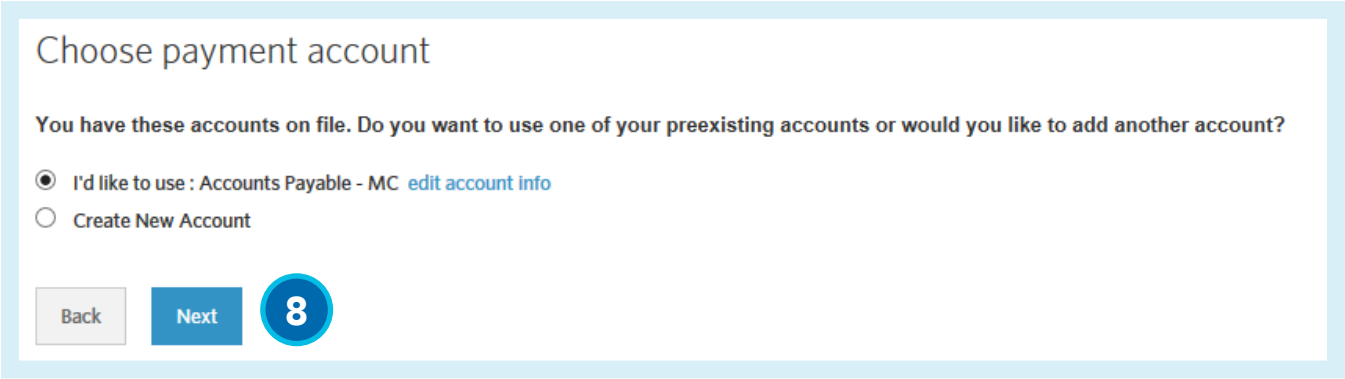
Step 7:

Select **Make online payment**, and select **Next**.



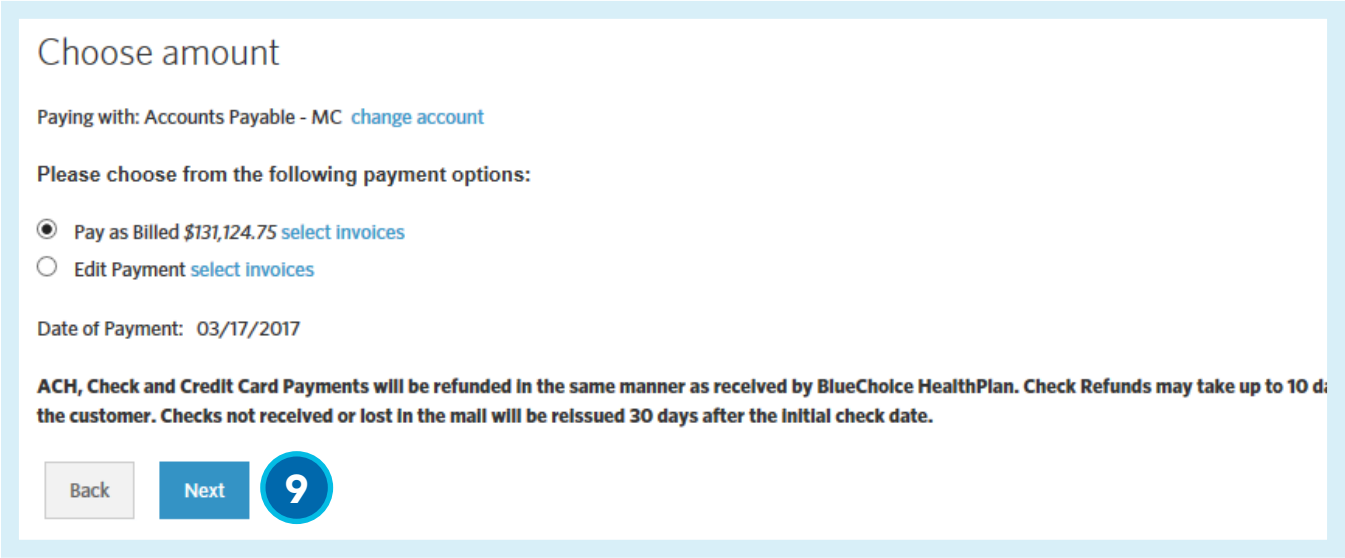
Step 8:

Choose how you would like to pay, and select **Next**.



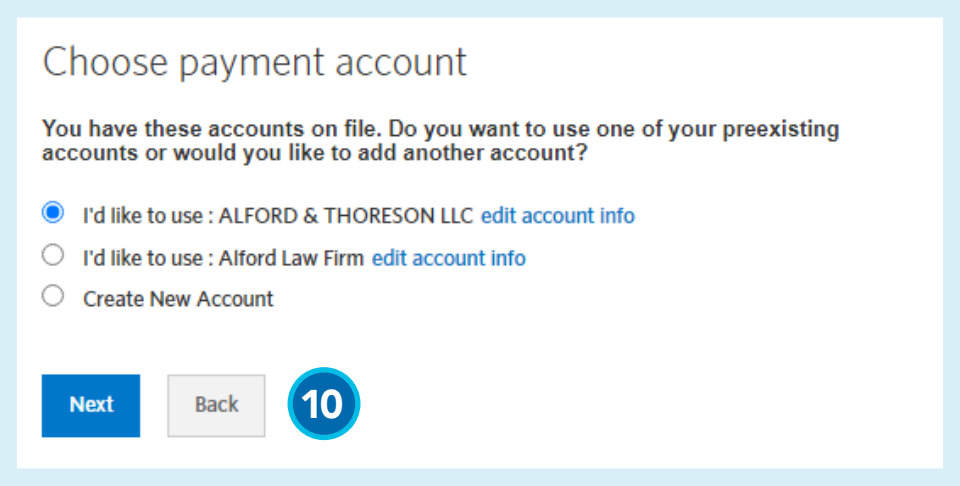
Step 9:

Choose the amount you would like to pay and the date. Select **Next**.



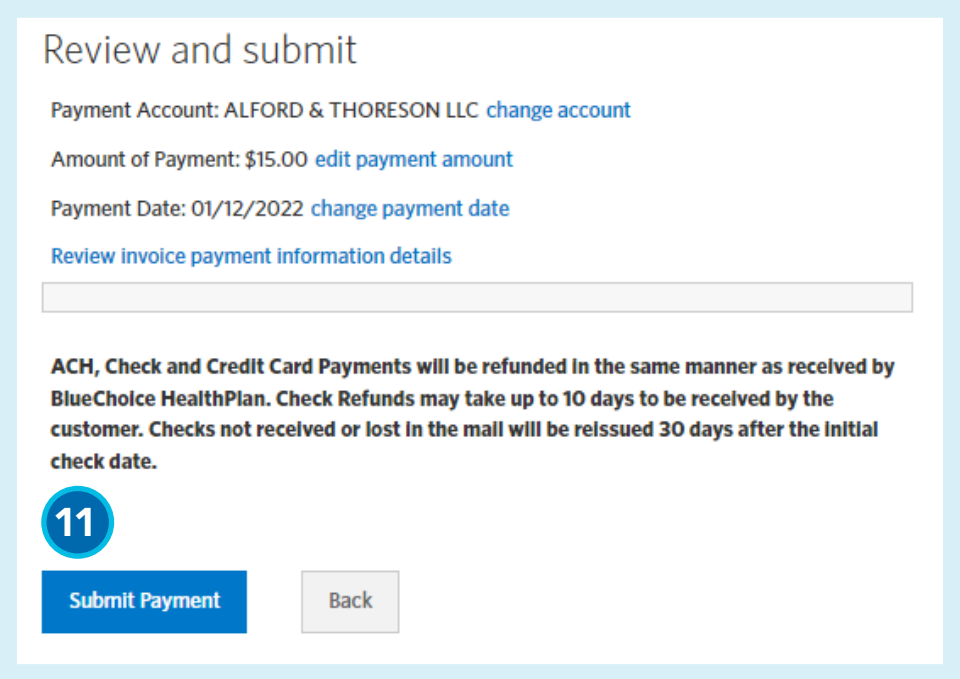
Step 10:

Choose the payment account. Select **Next**.



Step 11:

Select the **Submit Payment** button. After the payment is submitted, you should get a confirmation number.



5.4 Key Dates To Review a Bill

You will get an email notification each month stating an invoice is ready to view on *Quick*Bill. When you receive the email, you should log in to your account to view the invoice and pay it by the date it is due to avoid interruption of coverage.

Section 6: Member Services

BlueChoice has member advocates available to help your covered employees with their questions. This section will outline some of the questions we receive, including where to direct your covered employees if they need to contact us.

6.1 Member Liability

BlueChoice's and BlueCard's participating physicians, hospitals and other providers must bill us directly. Members should not be balance billed from any participating provider for any covered services.

6.1.1 Open-Access Plans

Most of the time, your covered employees pay at the time of service and should not receive any bills. They should talk to the providers if the providers bill for anything other than copayments, deductibles, coinsurance or non-covered services. Your covered employees should ask if payments may have been made by BlueChoice that are not yet reflected on their bills. They can also check the Explanation of Benefits (EOB) online through My Health Toolkit to see how much they should owe providers. (See Section 7 to learn how your covered employees sign up for accounts.) If providers bill them after payments have been made, your covered employees should contact BlueChoice at the phone number listed on the back of their member ID cards.

6.1.2 High-Deductible Health Plans (HDHP) (if applicable)

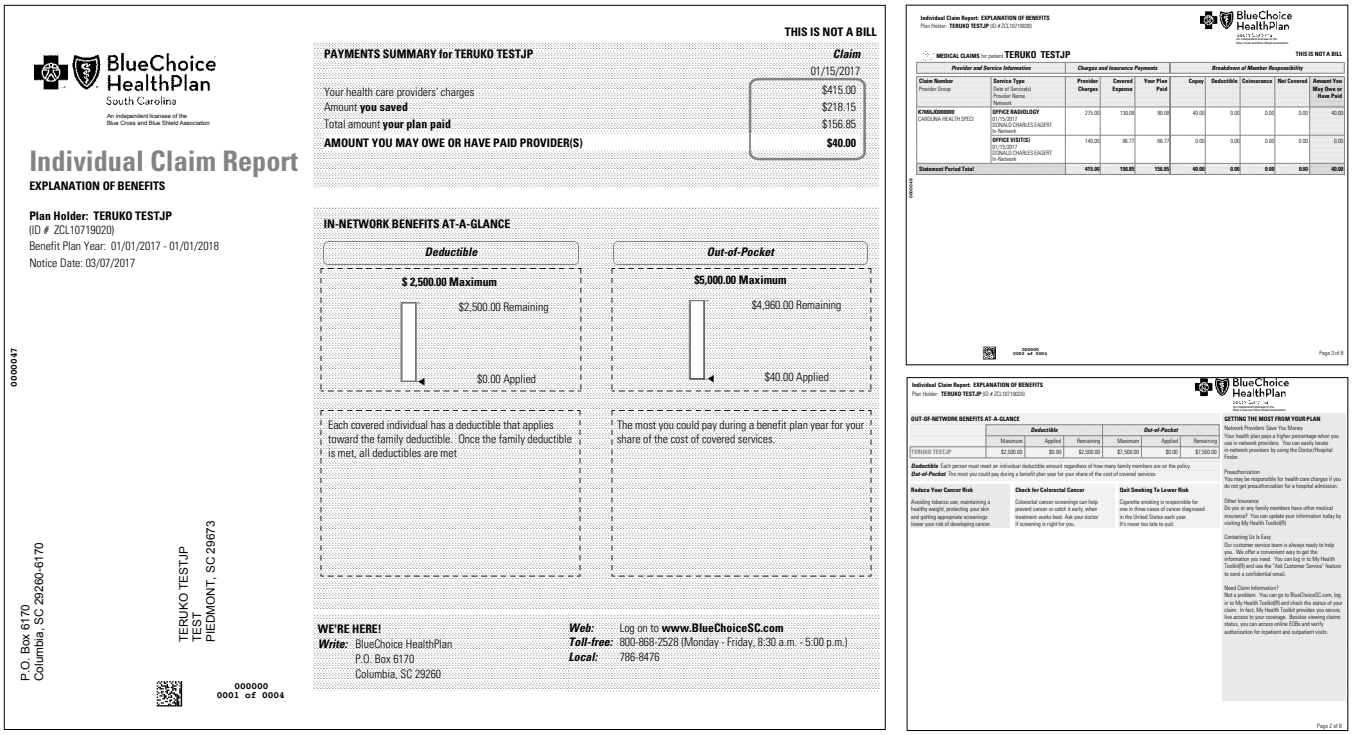
Most of the time, your covered employees pay at the time of service and should not receive any bills. However, if your covered employees have a high-deductible health plan (HDHP), they may receive bills after receiving services. Some doctors prefer to file the claims and then send bills.

Your covered employees can check their EOBs online through My Health Toolkit to see how much they will owe the providers. (See Section 7 to learn how your covered employees sign up for accounts.) If the employees receive bills for anything other than the amount indicated on the EOBs, they should contact the providers to ask if payments have been made by BlueChoice that are not yet reflected on their bills. If providers bill them after payments have been made by BlueChoice, they should contact BlueChoice at the phone number listed on the back of their member ID cards.

6.2 Explanation of Benefits

Your covered employees will receive a Summary EOB about once a month if they have used any of their benefits. They can choose if they would like to receive them in the mail or electronically by signing up for a free My Health Toolkit account. (See Section 7 to learn how your covered employees can sign up for accounts.) The last step of registration is to select how they would like to receive their paperless EOBs.

Each Summary EOB gives information for claims we processed for all individuals under a member ID during the 21-day period. If your covered employees had claims filed or processed during that time period, BlueChoice will send Summary EOBs. If no claims are filed or processed, they won't receive Summary EOBs for that period.



THIS IS NOT A BILL

BlueChoice HealthPlan
South Carolina
An independent licensee of the Blue Cross and Blue Shield Association

Individual Claim Report
EXPLANATION OF BENEFITS

Plan Holder: TERUKO TESTJP
(ID # ZCL10719020)
Benefit Plan Year: 01/01/2017 - 01/01/2018
Notice Date: 03/07/2017

0000047

TERUKO TESTJP
TEST
PIEDMONT, SC 29673

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

000000
0001 of 0004

PAYMENTS SUMMARY for TERUKO TESTJP

	Claim 01/15/2017
Your health care providers' charges	$415.00
Amount **you saved**	$218.15
Total amount **your plan paid**	$156.85
AMOUNT YOU MAY OWE OR HAVE PAID PROVIDER(S)	**$40.00**

IN-NETWORK BENEFITS AT-A-GLANCE

Deductible	*Out-of-Pocket*
$ 2,500.00 Maximum	**$5,000.00 Maximum**
$2,500.00 Remaining	$4,960.00 Remaining
$0.00 Applied	$40.00 Applied
Each covered individual has a deductible that applies toward the family deductible. Once the family deductible is met, all deductibles are met	The most you could pay during a benefit plan year for your share of the cost of covered services.

WE'RE HERE!
Write: BlueChoice HealthPlan
P.O. Box 6170
Columbia, SC 29260

Web: Log on to **www.BlueChoiceSC.com**
Toll-free: 800-868-2528 (Monday - Friday, 8:30 a.m. - 5:00 p.m.)
Local: 786-8476

Summary EOBs provide all the information your covered employees need about their health insurance claims — and they are easy to read and understand. The summary section outlines the costs BlueChoice covered and the amounts your covered employees owe specific providers. It also shows other insurance or Medicare payment amounts if applicable. Your covered employees will find definitions of some terms and an explanation of their appeal rights. The claims detail section gives more information about each claim, such as charges, allowed amounts and coinsurance. It also explains where your covered employees stand on deductibles and out-of-pocket amounts.

If your covered employees receive Summary EOBs but would like to view an individual EOB for a particular claim, they can log in to **My Health Toolkit** and select the **Health Claims Status** link under the **Benefits** tab.

6.3 Coordination of Benefits

BlueChoice works hard to control the rising costs of medical care. One way we do this is through coordination of benefits (COB). The South Carolina 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 your covered employees who are subscribers under one health plan and dependents under another one. The COB guidelines determine the exact order of payment between BlueChoice and the other insurance carrier. The EOB breaks down the payment responsibilities of the insurance carrier and your covered employee. If BlueChoice is the secondary carrier, we must receive an EOB from your covered employee'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 is the secondary carrier, your covered employee should follow our policies and procedures (network providers, referrals, etc.) to receive benefits. If a covered 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.

6.4 Medicare Coordination

When BlueChoice covers active employees with Medicare, BlueChoice is the primary carrier. BlueChoice is also the primary carrier for retirement-age employees with Medicare coverage who are still actively employed.

6.5 Subrogation

BlueChoice has the right of subrogation. This means we can recover from a third party the cost of your covered employee's health care for injuries or illnesses for which another party was responsible. If your covered employee received a settlement as a result of an accident or legal claim, BlueChoice can seek recovery from your covered employee or the third party.

6.6 Appeal Procedures

To appeal a decision regarding the provision of benefits under your contract, your covered employee can contact a representative of BlueChoice, stating the issue to be reviewed and attaching pertinent medical records or other information in support of the appeal.

Your covered employee also can request a description of any pertinent records that BlueChoice reviewed in making the original decision to deny the claim in whole or in part. If the complaint involves a representative of BlueChoice, the request should be addressed to the chief operating officer of BlueChoice. If a complaint is related to the quality of care received by your covered employee, it is considered a grievance. Your covered employee should submit a description of the problem in writing to a BlueChoice representative.

A BlueChoice representative will notify your covered employee of receipt of the complaint or appeal and will arrange for a review by an appropriate representative of BlueChoice. A pre-service complaint or appeal shall be resolved within 30 days from the date received. Post-service complaints or appeals shall be resolved within 60 days from the date received. This period may be extended in the event of a delay in getting the documents or records necessary for the resolution of the matter.

If the problem is an appeal of the denial of an authorization, your covered employee can request that the individual who reviews the request be a person who did not make the initial decision of denial. He or she can request that the reviewer be a provider licensed in the same specialty as the attending medical provider. If your covered employee believes the determination to deny authorization warrants immediate appeal, he or she can request an expedited appeal. For an expedited appeal, a decision shall be made and your covered employee shall be notified of the decision within 72 hours of BlueChoice'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 employee can resubmit the appeal through the standard appeals process.

All claims, questions, grievances or appeals must be submitted within 180 days after the later of the date services were rendered or the date the claim for services was denied. After this period, disposition of the claim shall be considered final. Any question or appeal your covered employee has concerning an authorization must be made to BlueChoice within 180 days from the date the authorization was approved or denied by BlueChoice. Otherwise, the decision shall be considered final.

6.6.1 External Review by an Independent Review Organization

In certain situations, your covered employee may be entitled to an additional review of the appeal at BlueChoice's expense. Requests to cover services, benefits or supplies excluded in the contract/certificate are not eligible for external review. The employee will be notified in writing of the right to request an external review. Employees should submit a written request for external review within four months of receiving that notice. The employee will be required to authorize the release of any medical records that may be needed for the external review. If the employee needs assistance during the external review process, he or she can contact the South Carolina Department of Insurance at the following address and telephone number:

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

We will respond within five business days of the employee's request for an external review by either notifying the South Carolina Department of Insurance of a request for external review and requesting the South Carolina Department of Insurance assigns the review to an independent review organization (IRO) and forwarding the records to it or telling the employee in writing the situation doesn't meet the requirements for an external review and explaining the reasons. The South Carolina Department of Insurance will assign an IRO based on a rotational system. The rotational system will be independent and impartial, and in no event will the IRO be assigned by BlueChoice or the member. BlueChoice will verify that no conflict of interest exists with the assignment given by the South Carolina Department of Insurance. If a conflict does exist, BlueChoice will contact the South Carolina Department of Insurance for a change in IRO.

The employee has five business days from the date he or she receives our response to submit additional information to the IRO in writing. The IRO must consider this additional information when conducting its review. The IRO will also forward this information to us within one business day of its receipt.

If the request is assigned to an IRO, the IRO will determine within five business days after receiving the request whether all the information, certifications and forms required to process an external review have been provided. If the IRO needs additional information, the employee can submit additional information in writing within seven business days.

If the employee's request is not accepted for external review, the IRO will inform the employee and us in writing of the reason(s) the request was not accepted.

The IRO will provide written notice of its decision within 45 days after it receives the request.

If the IRO's decision is to allow benefits, we must process the claim subject to applicable contract and certificate exclusions, limitations and other provisions within five business days of our receipt of the notification.

Section 7: Web Tools and Services

7.1 Web Address — www.BlueChoiceSC.com

Our website has a variety of tools to help your covered employees. They can download forms, find a prescription drug list, access the member guide or read about wellness programs. They can also:

- Get plan and product information.
- Find participating medical providers or facilities.
- Learn about our wellness program **FOCUS***fwd* and our Great Expectations® *for health* programs.

7.1.1 Resources To Share With Your Employees

There are helpful resources you can share with your employees on the resources page at www.BlueChoiceSC.com/engage.

Check out the flyers, posters and videos. The resources page even has pre-populated email templates. Simply select the link, enter the email addresses of the recipients and send to your employees.

There are resources available in these categories:

- Find Care
- My Health Toolkit
- Health Management Programs
- **FOCUS***fwd* Wellness Incentive Program
- Making the Most of Coverage
- Discounts & Added Values

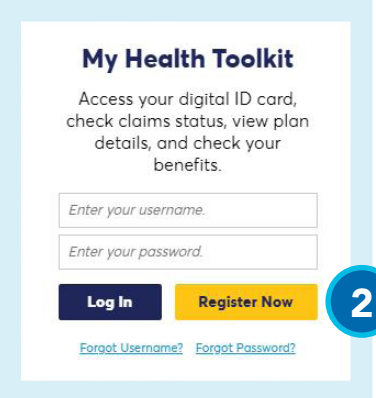
Scan this QR code to learn how to make the most of your coverage with our easy-to-use online resources.

7.2 My Health Toolkit

Your covered employees can use My Health Toolkit to access claims, health and other coverage information. When they register, they can:

- View their digital ID cards.
- See if their claims have been paid.
- Ask Member Services a question.
- Access the **FOCUS***fwd* Wellness Incentive Program.
- Find a doctor or hospital.
- Find out how much a prescription drug costs.
- Take a Personal Health Assessment.
- Find out how much they have paid toward their deductibles.
- View their Schedules of Benefits, which include their copayment and coinsurance amounts.

Covered spouses and dependents ages 16 years and older can register their own accounts.



7.2.1 Sign Up for My Health Toolkit

Your covered employees can sign up for a free My Health Toolkit account by following these steps:

Step 1:

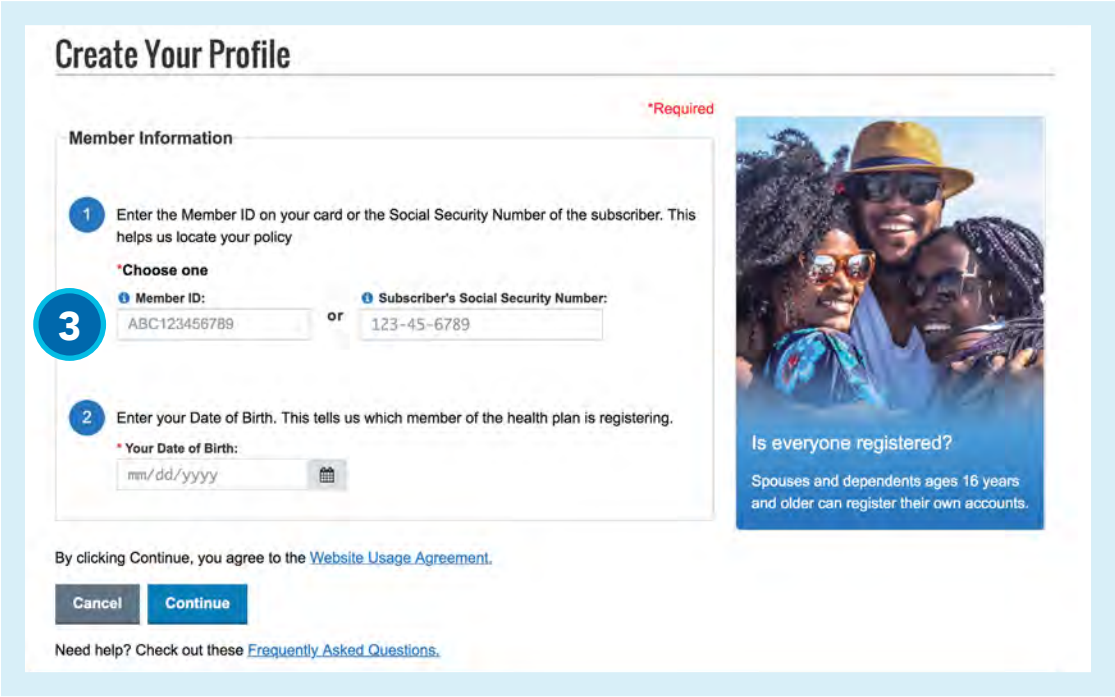
Go to www.BlueChoiceSC.com.

Step 2:

Select **Register Now.**

Step 3:

Enter the member ID on the front of the member ID card or the subscriber's Social Security number, along with the member's date of birth. When entering the member ID, make sure to include both the letters and the numbers.

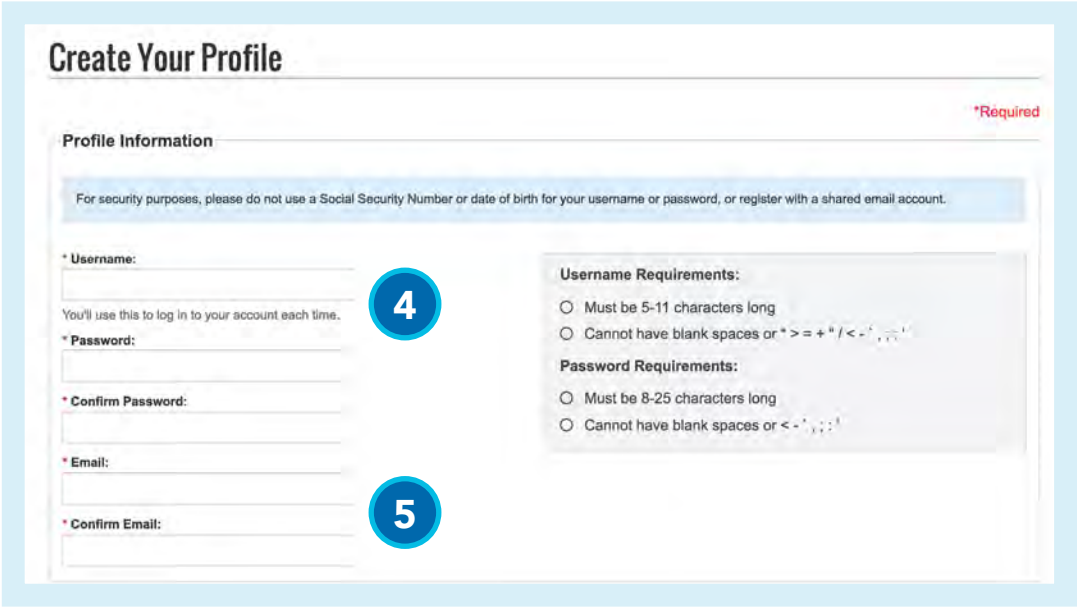


Step 4:

Choose a username and password.

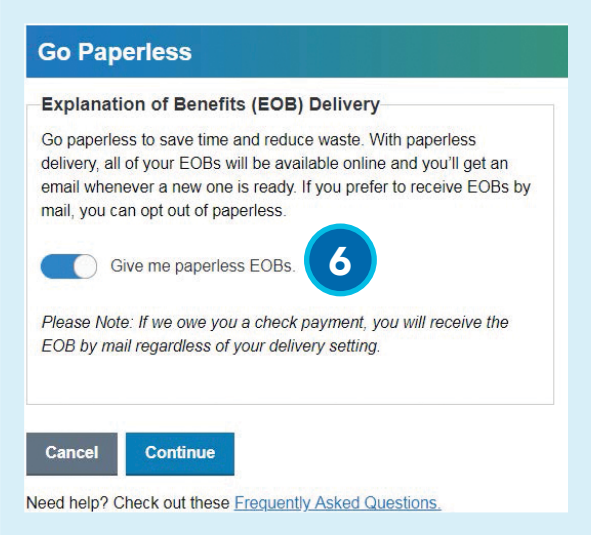
Step 5:

Enter an email address and confirm it.



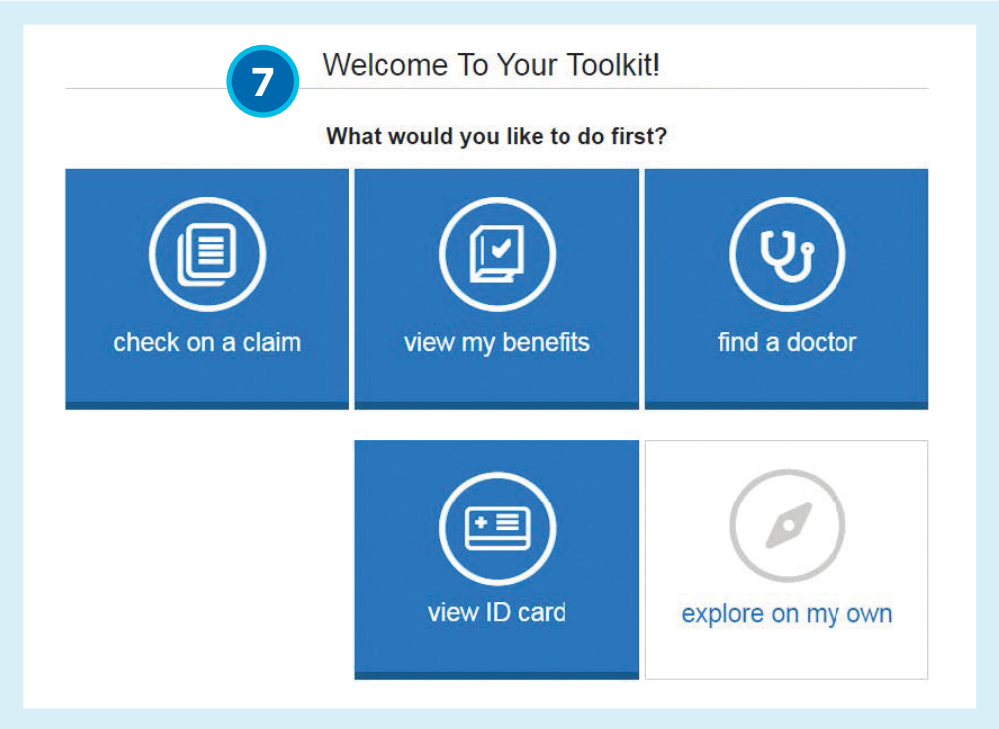
Step 6:

To receive paperless EOBs, move the slider bar to the right and select Continue. Otherwise, only select Continue.

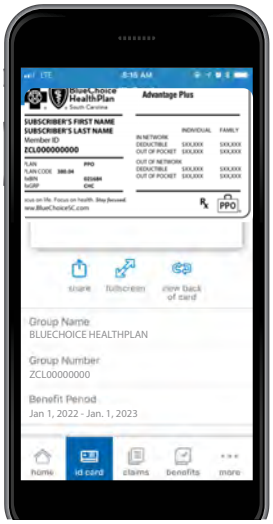


Step 7:

The launch page for first-time visitors appears.



7.2.2 My Health Toolkit App



Your covered employees can use the free My Health Toolkit app to:

- View and share their digital ID cards.
- Check the status of their claims.
- Confirm coverage.
- Find doctors or hospitals in network.
- Update their contact information.
- Access the **FOCUS***fwd* Wellness Incentive Program.

Current My Health Toolkit users can log in to the app with their existing usernames and passwords. New My Health Toolkit users can register through the app.

Get the App

Search for "My Health Toolkit" in the App Store or Google Play to download the My Health Toolkit app.

7.2.3 Cost Estimates

Your covered employees can use **Find Care** in My Health Toolkit to find the estimated cost of a service across providers, like an office visit or radiology test. This gives your covered employees personalized information so they can make informed decisions about health care treatment options.

The results show dollar-amount estimates specific to their benefits and the treatments they researched. They can also sort the information based on features that are important to them, such as these:

- Average cost of particular treatments or services
- Estimated out-of-pocket costs
- Distance from home to facility
- Whether a facility is a Total Care facility, a designation by the Blue Cross Blue Shield Association for medical facilities that have demonstrated expertise in delivering quality health care

To access cost estimates, your covered employees should:

- Visit www.BlueChoiceSC.com.
- Log in to **My Health Toolkit**. Your covered employees can register for a free account if they do not have one.
- Select the **Resources** tab, and select the **Find Care** link.

7.3 Text Messages

Members can get important information delivered to their smartphones when they sign up for our text messages.

Messages include:

- Keys to using their coverage.
- Health and wellness reminders.
- Ways to save and more!

To get started, simply call 844-206-0622. The member will need to have his or her member ID card ready.

7.4 FOCUS*fwd* Wellness Incentive Program

The **FOCUS*fwd*** Wellness Incentive Program is designed to help members lead healthier lifestyles. By completing health-related activities and challenges, members earn up to **$110 in rewards** and increase their chances of winning one of the **$1,000 quarterly** and **$5,000 annual cash rewards** in our **Sweepstakes**!

FOCUSfwd® WELLNESS INCENTIVE PROGRAM

$70 FOCUS Points

Members get a **$70 reward** and **40 Sweepstakes entries** for completing an individual Personal Health Assessment, annual wellness exam, and preventive screening or flu vaccine.

$40 GET FIT

Members get up to **$40 in rewards** and **40 Sweepstakes entries** for completing the quarterly step challenges.

$5K Sweepstakes

Members earn entries into the **Sweepstakes** for every activity they complete in **FOCUS*fwd***, increasing their chances to win one of the **$1,000 quarterly** and **$5,000 annual cash rewards. Members earn 10 Sweepstakes entries** by simply signing up for **FOCUS*fwd***.

7.5 The **FOCUS***fwd* App Is Here!

Members can stay connected to rewards anytime, anywhere with the **FOCUS***fwd* app.

With the **FOCUS***fwd* app, members can:

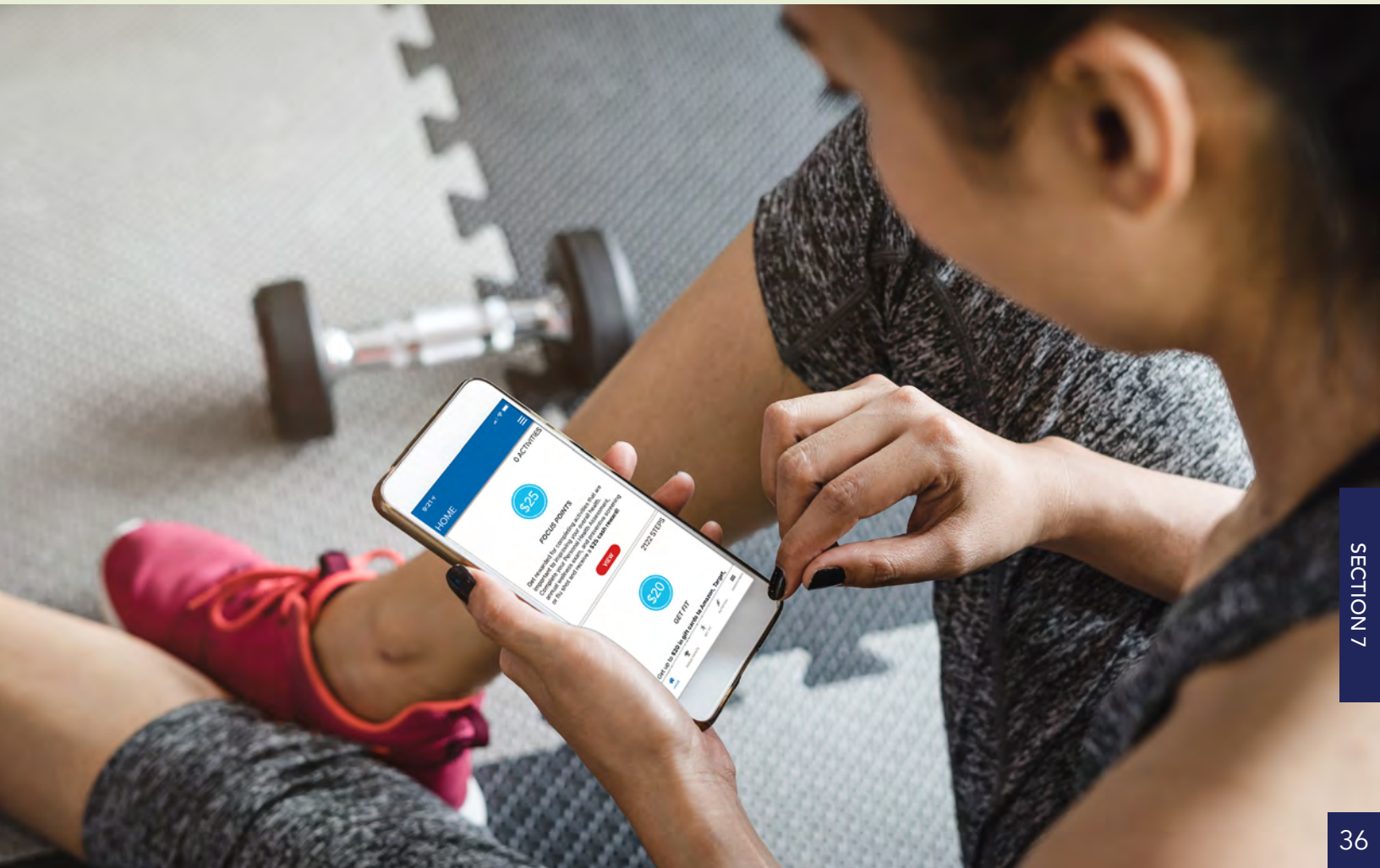
- Complete activities in **FOCUS Points** that are important to their overall health.
- Register and participate in the annual GET FIT step challenge.
- Connect their activity trackers to start participating in GET FIT.
- Complete activities that help them stay connected to BlueChoice HealthPlan and improve their health, all while earning entries into the **FOCUS***fwd* Sweepstakes.
- Redeem their **FOCUS***fwd* rewards.

Downloading the FOCUS*fwd* app and linking an account:

1. Log in to **My Health Toolkit** on your mobile device.
2. Select **FOCUS*fwd* Wellness Incentive Program** under **Benefits**.
3. Select the **Learn More** button.
4. Select the **Link FOCUS*fwd* Account** button.
5. You will automatically be directed to the App Store or Google Play.
6. Download the **FOCUS*fwd*** app.
7. Open the app.

Available on the iPhone App Store

ANDROID APP ON Google play



7.6 Health Management Programs

Comprehensive health management is an integral part of the services we offer to BlueChoice members. We use a 360-degree approach in managing the health of your employee population and their families through our **Great Expectations *for health*** programs. We offer programs in four categories, which span the spectrum of health and disease:

- **Prevention and Wellness:** These programs support behavioral changes that improve overall member well-being and prevent the development of serious, costly health conditions.
- **Behavioral Health:** Living with a behavioral health condition can feel overwhelming. These programs connect members with a personal care manager who can help them better understand their conditions and the steps they can take to achieve their best health.
- **Condition Support:** Living with a chronic health condition can be challenging. These programs provide targeted, condition-specific education, counseling and support from our team of highly trained health specialists.
- **Critical Health Management:** These programs are specifically for members with severe conditions. Program participants get intensive care coordination and support from our caring team of nurses.

A brief summary of each program follows.

Prevention and Wellness

Back Care

The **Back Care** program helps members learn to be active members of their health care team. Participants receive information on how to effectively communicate with their health care providers, questions to ask their doctor and options for pain management, including physical and behavioral therapies, self-care and an action plan to prevent future problems. Members with severe, chronic back pain will be considered for case management.

Healthy and Active Kids

The **Healthy and Active Kids** program identifies children who are overweight or obese and offers their families education and interactive tools for adopting healthy habits.

Maternity

The **Maternity** program educates members about taking steps toward having a healthy baby.
We provide educational materials, support and monitoring throughout a member's pregnancy and postpartum period. The program is open to all eligible expectant mothers.

Tobacco Cessation

The **Tobacco Cessation** program provides support and resources to help members become tobacco free. This program guides members through deciding to quit, identifying triggers and overcoming the challenges of giving up tobacco.

Weight Management

The **Weight Management** program teaches members about healthy eating, exercise and behavior modification strategies to maximize weight loss and maintenance. Members who enroll in the program receive unlimited telephone access to a weight loss coach and digital tools designed to help them learn about the key principles of implementing a successful weight loss plan.

Behavioral Health

Adult Attention-Deficit Hyperactivity Disorder (ADHD)

The **Adult ADHD** program helps members develop a personalized plan for strategies to better manage their ADHD. The program assesses, empowers and educates members, providing them with tools to better understand ADHD and the best ways to manage it. Members can set their own goals and may also receive educational mailings, access to online resources and newsletters.

Anxiety Management

Anxiety Management assists members in developing personalized strategies to manage their anxiety. The program assesses, empowers and educates members, providing them with tools to better understand anxiety and the best ways to manage it. This program allows members to set their own goals. They may also receive educational mailings, access to online resources and newsletters.

Behavioral Health Case Management

We offer behavioral health case management to members with various behavioral health-related diagnoses. These can include depression, eating disorders, substance use disorder, bipolar disorder and schizophrenia. Clinically experienced behavioral health case managers work closely with members, their families and members' providers to ensure ongoing communication and coordination of care.

Bipolar Support

The **Bipolar** program helps members develop personalized strategies to manage their bipolar disorder. The program assesses, empowers and educates members, allowing them to identify and self-monitor their symptoms. Members can set their own goals for recovery and may also receive educational mailings, access to online resources and newsletters.

Depression

The **Depression** program helps members develop personalized strategies to manage their anxiety and depression. The program assesses, empowers and educates members using evidence-based interventions for symptom monitoring. Members can set their own goals for recovery and may also receive educational mailings, access to online resources and newsletters.

Moms Support Program

The **Moms Support** program helps moms across the childbearing spectrum to develop personalized strategies to manage their depression and anxiety at any stage, pre- or post-pregnancy. The program assesses, empowers and educates members, allowing them to identify and monitor their symptoms. Members can set their own goals for recovery and may also receive educational mailings, access to online resources and newsletters.

Recovery Support

The **Recovery Support** program helps members develop personalized plans for lifestyle modifications to manage their recovery from addiction. The program educates members about evidence-based techniques for coping with urges to use drugs or drink alcohol. Members may receive educational mailings, access to online resources and newsletters.

Disease Management

Asthma

The **Asthma** program helps members learn how to manage their asthma and improve their quality of life. Through ongoing partnership, collaboration and phone calls, our experienced respiratory therapists provide education about asthma and support for complying with each member's doctor's plan of care.

Chronic Kidney Disease (CKD)

The **Chronic Kidney Disease** program focuses on supporting members with stages 1, 2 and 3 CKD learn to manage their condition and reduce the risk of developing complications. The program educates members about lifestyle modifications and evidence-based guidelines for monitoring and controlling CKD risk factors. Members may receive educational materials about CKD-related topics, individualized coaching by phone, important health reminders and access to online resources. The program emphasizes the importance of having a personal physician to guide kidney health management, enhance kidney function and improve the member's quality of life. All BlueChoice members with diabetes are eligible to participate.

Chronic Obstructive Pulmonary Disease (COPD)

The **COPD** program helps members with COPD learn how to manage their disease. Our goal is to support members in practicing recommended self-care behaviors and following their physicians' plans of care. Members may receive educational materials by email, coaching phone calls and case management services.

Diabetes

The **Diabetes** program helps members learn how to manage their diabetes and reduce the risk of developing complications from their disease. The program consists of educational materials sent by email, telephone coaching, free glucose monitors and a free yearly diabetes doctor's office visit. We also help members take advantage of their benefits for eye exams and diabetes education, both at no additional charge to the member.

Heart Disease

The **Heart Disease** program is for members with coronary artery or ischemic heart disease. The program educates members about lifestyle modifications and evidence-based guidelines for the monitoring and control of cardiac risk factors, such as high cholesterol and high blood pressure. Members may receive educational materials by email, reminder phone calls and case management services.

Heart Failure

The **Heart Failure** program educates members with heart failure about appropriate self-care strategies to keep from making their condition worse. Members receive educational materials by email and counseling phone calls or case management services.

High Cholesterol

The **High Cholesterol** program is for members who want to learn more about managing their cholesterol. The program teaches members about lifestyle modifications and evidence-based guidelines for the monitoring and control of cardiac risk factors, such as high cholesterol. Members may receive educational materials via email, telephone coaching and access to online resources.

Hypertension

The **High Blood Pressure** program is for members who want to learn about managing their blood pressure. The program teaches members about lifestyle modifications and evidence-based guidelines for the monitoring and control of cardiac risk factors, such as high blood pressure. Members may receive educational materials by email, telephone coaching and access to online resources.

Migraine

The **Migraine** program is for adults who suffer from severe, recurrent headaches. We provide information about the importance of having a personal physician to guide headache management. Members may receive educational materials about migraine-related topics, telephone coaching and access to online resources. Members' personal physicians receive information on emergency room visits and medication prescribed by other physicians to improve the continuity of care in treating the member.

Metabolic Health

The **Metabolic Health** program helps members learn how to manage prediabetes and/or metabolic syndrome, a condition linked to being overweight or obese. Program participants receive educational materials by email and telephone coaching to encourage lifestyle changes that reduce the risk of developing complications such as Type 2 diabetes and heart disease.

Critical Health Management

Emergency Room (ER) Diversion Management

The **ER Care Guardian** program educates members on navigating appropriate levels of care in the health care system. The focus is on members who use the ER for nonemergency encounters that may have otherwise been managed at a primary care or urgent care level. A clinically experienced, licensed social worker and medical assistants promote strategies and resources to redirect members to alternate levels of care to avoid overuse of the emergency room for nonemergency conditions.

Neonatal Intensive Care Unit (NICU) Case Management

We offer the **NICU Case Management** program to infants who have certain conditions. These conditions include, but aren't limited to, complications associated with premature birth, congenital birth defects, hydrocephalus, seizures, cystic fibrosis and genetic disorders. Clinically experienced certified nurse case managers work closely with the caregiver and the member's providers to ensure ongoing communication and coordination of care.

7.7 My Health Planner

Let's face it: Health care is hard. But your employees don't have to go it alone. The My Health Planner app helps employees navigate the health system, meets employees where they are and supports the whole person. That means your organization can improve employee engagement, increase benefits utilization, achieve cost savings and improve employee satisfaction.

How Does My Health Planner Work?

When employees download the free My Health Planner app, they'll be paired with their very own care managers who can help them with their unique health and benefits needs.

Features of the app include:

- A checklist with daily tasks to complete and helpful articles to read — all tailored to employees' health needs or goals.
- A chat feature so members can talk with their care teams to ask health-related questions on their own time.
- Phone reminders to help keep track of medications and appointments.
- The Me tab, which shows a summary of progress over time.
- The Library section, where they can read articles about their health.

Tell your employees to:

- Visit www.MyHealthPlanner.com on a smartphone or tablet.
- Download the app and select Sign Up.
- Enter your organization's access code: SCVISIT.

Questions?

Email HealthCoaching@BlueChoiceSC.com, or call 855-838-5897, option 2.

Section 8: Employer/Employee Spending Accounts

8.1 Flexible Spending Accounts (FSAs)

You can choose to offer medical and dependent care FSAs for your employees through various vendors. Your account management team can help you with questions. You may also have to contact your vendor directly.

8.1.1 Important Reminders

- Expenses for an entire family may be reimbursed regardless of whether or not they are covered by the health or dental insurance.
- Election is irrevocable unless there is an Internal Revenue Service (IRS)-approved qualifying event.
- Use it or lose it: If employees don't use contributions made to the FSA by the end of the plan year and corresponding grace period, they will lose the remaining funds that exceed $500.
- The medical FSA annual election (total amount to be contributed for the year) is available at any time.
- Only the amount contributed to date is available under the dependent care FSA, and the ending date of service must occur before the reimbursement.

8.1.2 What's Covered

8.1.2.1 Medical FSAs

Medical FSAs allow your employees to save tax dollars on expenses that are not covered under their medical, dental or vision insurance and are not cosmetic in nature. Here is a list of common eligible expenses. For a full list of what is covered, please refer to IRS Publication 502:

- Acupuncture
- Allergy shots and testing
- Ambulance
- Artificial limbs and teeth
- Asthma treatment
- Blood pressure monitoring devices
- Braces and supports
- Chiropractor
- Contact lenses
- Deductible amounts
- Dental treatment
- Dentures
- Dermatology
- Diabetic equipment and supplies
- Durable medical equipment (DME)
- Eye exams
- Eyeglasses
- Flu shots
- Health screenings
- Hearing aids and batteries
- Home health and hospice
- Hospital services
- Laboratory fees
- Laser eye surgery
- Maternity charges
- Occupational therapy
- Orthodontia
- Physical therapy
- Prescription drugs
- Psychiatric care
- Speech therapy
- Substance abuse counseling
- Transplants
- Vaccinations

Examples of eligible over-the-counter (OTC) items that do not require a prescription:

- Ankle/knee supports
- Bandages (nonmedicated)
- Blood glucose test strips
- Blood pressure monitor
- Contact lens solution
- Crutches
- Elastic bandages (ACE™ wraps)
- First aid kits
- Gauze pads
- Heat wraps
- Ice packs
- Pregnancy tests
- Pulse oximeters
- Sunblock
- Thermometers

8.1.2.2 Dependent Care FSAs

The dependent care FSA provides a tax savings for expenses incurred toward the care of a child, parent or disabled dependent. To be eligible for the dependent care FSA, your employee must meet the following IRS requirements:

- Dependent must be under age 13 and considered your employee's dependent under tax rules.
- The expense must enable your employee (and his or her spouse, if married) to work, actively seek work or attend school full time.
- The caregiver cannot be your employee's dependent child under the age of 19.
- The caregiver must claim dependent care payment as income.
- Only expenses deemed as custodial care are eligible. Additional charges for meals, diaper fees, late payment fees, etc. are not eligible.
- Expenses incurred for the care of a mentally or physically disabled spouse or adult dependent are eligible only if your employee is claiming that individual as a tax dependent.

8.1.3 Debit Cards

Some vendors offer debit cards for your employees to purchase eligible medical expenses from providers. Qualified merchants include the following:

- Doctors
- Hospitals
- Dentists and orthodontists
- Retail merchants using the Inventory Information Approval System
- Vision providers
- Pharmacies

8.1.3.1 Electronically Verified Purchases

When your employees use their cards for doctor copayments, prescription copayments and eligible over-the-counter items, their cards should auto-substantiate. When the purchase is auto-substantiated, it means that the system can electronically verify that the expenses are valid and your employees will not need to verify what they purchased by submitting paper receipts.

8.1.3.2 Non-Electronically Verified Purchases

Sometimes, an employee's purchases may not be electronically verifiable. This can happen because:

- The copayment amount and the merchant code do not match. Providers who accept debit cards are assigned a merchant category code. There are more than 500 merchant category codes. Only the health care merchant codes related to eligible expenses under your plan are programmed on the card.
- It is a transaction that is not programmed for his or her card.

If an employee has a purchase that was not electronically verified (auto-substantiated), then he or she must submit documentation to show the purchase is a qualified expense.

- Documentation can be an itemized paper receipt or EOB.
- Failure to submit documentation may cause the card to be suspended until the transaction has been resolved.

Check with your vendor for details.

8.1.4 Proper Documentation When Filing Claims

If an employee has a purchase that requires documentation, he or she must complete an FSA claim form and submit it along with proper documentation of the expense.

Documentation for medical reimbursements should include the name of the person incurring the service, provider name, date of service, type of service that was incurred and the amount charged minus any amount that has been or will be paid by insurance or other sources.

Over-the-counter medication documentation should include a receipt showing the name of the medicine, date of purchase, provider name and amount. The employee must provide supporting documentation, such as a prescription or physician's statement, to be reimbursed.

Day care documentation should include the name of the child, name of the provider, beginning and ending date of service, and amount charged. If the day care provider is an individual, then the documentation should include that person's signature and his or her tax ID or Social Security number.

Cash register receipts, canceled checks, and credit card receipts or statements are not acceptable forms of documentation.

8.2 Health Reimbursement Account (HRA)

You can choose to offer an HRA for your employees with various vendors. Your account management team can help you with questions. You may also have to contact your vendor directly.

8.2.1 Claim Submission

Typically, your vendor will receive medical claims directly from the insurance carrier, so your employees don't need to file claims. Once claims are received electronically from the providers and processed, the payments are issued directly to the providers.

8.2.2 Proper Documentation

If your employees need to file claims, they will have to submit the proper documentation.

Documentation for medical reimbursements should include the name of the person incurring the service, providers' names, dates of service, types of service incurred and the amounts charged minus any amounts that have been or will be paid by insurance or other sources.

Over-the-counter medication documentation should include a receipt showing the names of the medicines, dates of purchase, providers' names and amounts. Employees must provide supporting documentation, such as prescriptions or physicians' statements, to be reimbursed.

Day care documentation should include the names of children, names of the providers, beginning and ending dates of service, and amounts charged. If day care provider is an individual, then the documentation should include that person's signature and his or her tax ID or Social Security number.

Cash register receipts, canceled checks, and credit card receipts or statements are not acceptable forms of documentation.

8.3 Health Savings Account (HSA)

If you offer your employees a qualified high-deductible health plan (HDHP), you can choose to offer HSAs through various vendors. Your account management team can help you with questions. You may also have to contact your vendor directly.

8.3.1 Annual HSA Contribution Limits

Contributions made by all parties into an HSA cannot exceed the HSA limit set by the IRS. Anyone can contribute to your employees' HSAs, but only the accountholders and employers can receive tax deductions on those contributions.

The contributions and catch-up contributions change annually. To see the current amounts, visit www.IRS.gov.

8.3.2 What's Covered?

Your employees can use HSA dollars to help pay the health insurance deductible and any qualified medical expenses, including those not covered by health insurance, like dental and vision care.

A qualified medical expense is one for medical care as defined by Internal Revenue Code Section 213(d). Most expenses for medical care will fall under IRC Section 213(d). However, some expenses do not qualify. You can view a list of these expenses at www.IRS.gov.

Here are some examples of eligible medical expenses:

- Acupuncture
- Allergy shots and testing
- Ambulance
- Artificial limbs and teeth
- Asthma treatment
- Blood pressure monitoring devices
- Braces and supports
- Chiropractor
- Contact lenses
- Deductible amounts
- Dental treatment
- Dentures
- Dermatology
- Diabetic equipment and supplies
- Durable medical equipment (DME)
- Eye exams
- Eyeglasses
- Flu shots
- Health screenings
- Hearing aids and batteries
- Home health and hospice
- Hospital services
- Laboratory fees
- Laser eye surgery
- Maternity charges
- Occupational therapy
- Orthodontia
- Physical therapy
- Prescription drugs
- Psychiatric care
- Speech therapy
- Substance abuse counseling
- Transplants
- Vaccinations

Generally, your employees can use their HSAs for dependents not covered by health insurance.

8.3.3 Nonmedical Withdrawals

HSA distributions used for any purpose other than the qualified medical expenses listed will be taxable, and the appropriate tax rules will apply.

If an individual is age 65 or older, regardless of whether the individual has been enrolled in Medicare, there is no penalty to withdraw funds from the HSA. Normal income taxes will apply if the person does not use distributions for expenses not covered by the medical plan.

Focus on life. Focus on health. *Stay focused.*

We want to thank you again for being a valued customer. Our goal is to provide you with an excellent experience. We are here to help you navigate your benefits. If you have any questions or concerns, always remember that we are here to serve you.

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216470-3-2023