How Your Benefits Work

Your Member Guide to Carolina Advantage Coverage
This is your BlueChoice HealthPlan Member Guide, which outlines your benefits and covered services. The first section is **Your Benefits at a Glance**. Please review this section, which provides a brief review of many important issues. If you need more detailed information about a topic, please read the expanded information in the back of the guide.

We are pleased that you have selected us to be your health plan. Remember, we’re here to help you. If you need more information about anything in the Member Guide, or have other questions, please contact Member Services in one of the these ways:

**If you need an interpreter, we have services available for both oral and written assistance. If you have questions about your coverage, please contact Member Services for more information. If you have a question about utilization management, you can contact Member Services. If they are unable to answer your question, Member Services can transfer your call to utilization management staff or, after normal business hours, to an individual who can forward your call to utilization management staff.**

Other documents referred to in this Member Guide will help you better understand your specific coverage and benefits, such as your copayments for prescription drugs and office visits, exclusions, etc. Here’s how to access these documents:

**Schedule of Benefits:** This is a list of your employer’s unique coverage and benefits. The Schedule of Benefits includes the benefit categories and what you will pay for each service. You can access this through our website at www.BlueChoiceSC.com. From the Members page, select the My Health Toolkit® link. The first time you go to My Health Toolkit, you will need to create an account. From the sign-in page, select Register Now.

Once you have created a profile, you will have access to your Schedule of Benefits. Select the Eligibility and Benefits tab at the top of the page. Then select the blue text that reads Health Eligibility and Benefits and select View Benefit Booklet.

**Certificate of Coverage:** This is an in-depth description of covered services, exclusions, limitations and eligibility requirements. You can find your Certificate of Coverage through a link at the top of your Schedule of Benefits, or request a copy of your group benefits booklet from your Human Resources department or Member Services.

One more thing: We know that there are a lot of insurance words that may be confusing. Common insurance words and terms are defined in the glossary on page 27. Thank you for choosing BlueChoice®.

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.
## Your Benefits at a Glance

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<td>Get an overview of your plan</td>
<td>The <strong>Carolina Advantage</strong> plan gives you the flexibility to choose where you receive medical care, as long as you use in-network (participating) providers. We provide coverage only for medically necessary services that we listed as covered in your <strong>Schedule of Benefits</strong>. You should also check your <strong>Certificate of Coverage</strong> which can be found on our website <a href="#">here</a>, to see any exclusions or limitations of your plan. Remember to show your member ID card whenever you get medical services.</td>
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<td>See a doctor</td>
<td>Your plan allows you to see a primary care physician or specialist you choose, without getting prior approval (authorization). Inpatient and certain outpatient mental health or substance abuse services require prior approval. We strongly recommend, however, that you have one doctor who knows you and your medical history and can coordinate care with specialists and other providers.</td>
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<td>Be admitted to the hospital</td>
<td>All inpatient care must be authorized in advance, except for emergency admissions. Your primary care doctor or specialist will coordinate this for you. If you have an emergency and are hospitalized, please call BlueChoice (or have a family member or friend call) within 24 hours or the next business day. See your <strong>Schedule of Benefits</strong> to find out more about inpatient deductibles and coinsurance.</td>
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<td>Get emergency care</td>
<td>If possible, call your primary care physician. If there’s no time to do that, call 911 and/or get to the nearest emergency room (ER) for care. It must be a true emergency for you to have coverage at an ER. See your Schedule of Benefits to find your ER copayment.</td>
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<tr>
<td>Get urgent care</td>
<td>Sometimes, you may have a need for medical care that can’t wait for your physician’s normal office hours, but is not an emergency. You can go to a participating urgent care center. See your Schedule of Benefits to find out what copayment applies. (Hint: Urgent care copayments are much lower than ER copayments.)</td>
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<td>Fill a prescription</td>
<td>You may have prescription benefits with BlueChoice. Please see your Schedule of Benefits to find out. If your plan has drug benefits, your ID card is also your prescription card. Take your ID card and your prescription to any network pharmacy, and it will fill up to a 31-day supply. Your plan covers most drugs, except for lifestyle drugs. Effective Jan. 1, 2017, your plan now offers a Tiered Preferred Drug List (PDL), which has six tiers. See your Schedule of Benefits to find out which PDL your group currently has and what you will pay for each tier.</td>
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<td>Get other services</td>
<td>Your plan has coverage for laboratory and X-ray services. You also may have benefits for vision care.</td>
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<td>Get care away from home</td>
<td>With the BlueCard® network, you have access to in-network benefits when you are away from home, when you see a provider that participates in the network. If your card has a suitcase in the bottom right hand corner, you have this benefit.</td>
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## Your Benefits at a Glance

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<td>Learn about claims and other payment issues</td>
<td>You will receive an Explanation of Benefits (EOB) in the mail about every month, if you have used any of your benefits. EOBs are also available to you in My Health Toolkit. You also need to know about Coordination of Benefits (COB) and the required annual certification, as well as other paperwork issues. You can also learn about how we keep our benefits current with the latest advancements in health technology.</td>
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<tr>
<td>Learn about benefits for preventive care and how to stay healthy</td>
<td>We care about your health and want to encourage and support you in staying healthy. That’s why we cover preventive exams and immunizations. We also have great health and disease management programs to help you learn more about chronic conditions, pregnancy and healthy lifestyles.</td>
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<tr>
<td>Get information online</td>
<td>BlueChoice has one of the most useful websites around! You can search for a network doctor, check your claims status and authorizations, get information about our wellness programs and so much more.</td>
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<td>Understand policies and procedures and know your rights and responsibilities</td>
<td>As a BlueChoice member, you should understand all the “fine print” in your plan. You are also entitled to certain rights, including privacy and how we protect it, and you have certain responsibilities as a member. You also can appeal certain decisions.</td>
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<td>Learn insurance terms</td>
<td>Check out the Glossary for a definition of any words you don’t fully understand.</td>
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**Your Plan Overview**

When you need medical care, you can decide whether to go to an in-network or out-of-network doctor. You can choose either one. But if you go to an in-network doctor, it will cost significantly less.* You are responsible for making sure the doctor is in network before you receive a covered service. You can find this out two ways. You can use the Doctor & Hospital Finder on our website or you can contact Member Services. See the Introduction page of this guide for contact information.

*For preventive care, routine health screenings and well-baby and well-child visits, you must use an in-network doctor to receive benefits.

**In-Network Benefits**

We contract with a network of doctors, hospitals and other health care professionals to provide services to you. These in-network providers have agreed to:

- File all claims for covered services directly to us
- Collect copayment, coinsurance and deductible amounts from you (you can find the amounts you pay in your Schedule of Benefits)
- Accept what we have agreed to pay them as payment in full for covered services (minus any applicable coinsurance, copayment or deductible)

Remember: It will cost you a lot less if you use in-network doctors.

**Out-of-Network Benefits**

Out-of-network providers may file claims to us, but they don’t have to. They may refuse to file your claims, which means you may have to pay them directly and file a claim to us for reimbursement.

Your out-of-pocket costs will be more because you will have to pay higher copayments, deductibles and/or coinsurance for out-of-network care. Also, we will only pay out-of-network providers the allowable amount for a service. If the out-of-network provider charges more than the allowable amount, you will have to pay the difference, even if the service was authorized.

**What We Pay For**

We cover services that are medically necessary and that your plan lists as covered. See your Schedule of Benefits and Certificate of Coverage, which are available on our website or by contacting Member Services (see the Introduction page for contact information). Certificate of Coverage can be found here on our website. We pay for covered services you receive only while you are a member of BlueChoice.

Remember, BlueChoice must approve — in advance — all inpatient admissions to the hospital other than emergency admissions. You must notify us of non-emergency inpatient admissions at least two business days before the admission date. If you are uncertain if we have approved a service, please contact Member Services or check the website.

**What We Do Not Pay For**

Please refer to your Certificate of Coverage for a list of the services not covered under your plan. Services not covered are called exclusions. Services with restrictions are called limitations. You will be responsible for payment of non-covered services.

**Your ID Card**

Whenever you seek medical care, be sure to identify yourself as a BlueChoice member. When you arrive for your appointment, show them your BlueChoice member ID card.
Your Personal Physician
With your plan, you are not required to select a personal physician to coordinate your care. What’s a personal physician? It’s the main doctor you have, usually a primary care physician. Typically, primary care physicians specialize in family medicine, internal medicine or pediatrics (for children and adolescents). These doctors are trained to diagnose and treat many illnesses and manage chronic conditions, such as diabetes, high blood pressure and asthma. They can also provide preventive care, routine screenings and immunizations.

We encourage you to coordinate your health care through a primary care physician so you have one physician who is up-to-date and familiar with your medical history and all the care you receive. This may also cut down on unnecessary medical expenses.

We require all primary care physicians in our network to have 24-hour telephone service and another physician on call if they are unavailable. You have the security of knowing a medical professional is ready to help you 24 hours a day, seven days a week. Once you decide on a primary care physician you would like to see, all you have to do is call his or her office. Even if you get sick or injured after normal office hours, you can still call your doctor’s office and receive the help you need.

To find a provider in our network, you can go to the Doctor & Hospital Finder on www.BlueChoiceSC.com. There you will find practitioners’ names, specialties, addresses, telephone numbers, professional qualifications and much more! You can also get this information by contacting Member Services (See the Introduction page for contact information). We will give you directory information by telephone, email or in print upon request.

Most plans have one copayment for primary care physician visits and a higher copayment for specialist visits. See your Schedule of Benefits to find out the exact cost of your copayment when you see your doctor.

Routine Care
Routine appointments are for non-urgent medical needs. These include checkups, follow-up care and camp/school physicals. When making a routine appointment, try to call your primary care physician as far in advance as possible. Remember, we only cover preventive care, such as annual physicals, well-child exams and well-woman exams, if you use an in-network physician.

Gynecologist (GYN)
We provide benefits for women to receive regular, preventive care. If you go to a GYN who is part of our network of doctors, we cover your routine exam at the in-network benefit level. We also cover routine exams from your primary care physician. Be sure to confirm coverage levels in your Schedule of Benefits.

When You Need to See a Specialist
If you need to see a specialist, you can contact the specialist to make an appointment. (Please be aware that some specialists only accept patients referred from a primary care doctor.) If you receive care from one of our participating network specialists, you will have in-network benefits for services covered under your plan. If you choose to see an out-of-network specialist, please refer to your Schedule of Benefits to ensure that the specialist’s services are covered under your plan. Most plans have a specific copayment for office visits to a specialist. See your Schedule of Benefits to find out the exact cost.

Other Health Care Providers
Other network health care providers include hospitals, skilled nursing facilities, home health agencies, hospices and other providers of medical services and supplies. Please see your Schedule of Benefits for a complete list of your covered benefits. If you need one of these services (other than inpatient admissions), your plan allows you to self-refer to the provider of your choice.
If You Need to Be Admitted to the Hospital

To use benefit coverage for an inpatient admission, you must have authorization from BlueChoice. The hospital and your attending physician will coordinate this authorization process.

To find out if a hospital participates in the BlueChoice network, use the Doctor & Hospital Finder on our website at www.BlueChoiceSC.com or contact Member Services (See the Introduction page for contact information). You can ask to have a copy of this mailed to you.

If You Need Emergency Care

There may be times when you need emergency care. We encourage you to call your doctor, if possible, before you seek care in an emergency situation. If it is not possible to call your personal doctor, or delaying medical care would make your condition dangerous, please go to the nearest hospital. If you can’t get there on your own, call 911 for assistance. If your area doesn’t have 911 service, dial “0” and tell the operator it is an emergency.

Your plan has guidelines for benefits for emergency care services. If you receive emergency care without direction from your doctor, we will review your case carefully. Please realize that you may be responsible for payment if you receive emergency services that do not meet the guidelines of your plan.

Please review this information before an emergency occurs, so you’ll understand your health plan benefits. You can find more information about coverage for emergency care in your Schedule of Benefits and Certificate of Coverage. Certificate of Coverage can be found here on our website. Examples of situations that are not considered an emergency include:

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

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

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

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

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

One of our network physicians must provide or arrange all follow-up care. For example, if you go to the ER and get stitches, you should have a network physician remove them when it’s time. Returning to the ER for stitches removal would result in another copayment if your plan has a copayment for ER care.

If you are admitted to a hospital, have a family member call BlueChoice within 24 hours or the next business day.
A condition is considered urgent if it is not life-threatening, but still needs immediate attention in order to protect your health. Examples of urgent care conditions include:

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

If you have an illness or injury that requires urgent care, and you cannot get to your doctor or wait until normal office hours, services provided at a network urgent care center may be available. To find a network urgent care center, refer to the BlueChoice Doctor & Hospital Finder on our website at www.BlueChoiceSC.com or contact Member Services (See the Introduction page for contact information). Please keep in mind that your urgent care benefit and the associated copayment only refer to designated urgent care centers, not hospital facilities that advertise urgent care services. Please refer to your Schedule of Benefits to find out what your copayment is for urgent care services covered under your plan.
If You Need a Prescription Drug

Your plan includes prescription drug coverage. You can find a complete PDL, as well as a list of network pharmacies in South Carolina, quickly on our website.

What Is the PDL?
The PDL is the list of drugs we cover under your health plan. BlueChoice works with a team of health care providers to choose drugs that provide quality treatment. We cover drugs on the PDL, as long as:

- The drug is medically necessary
- One of our network pharmacies fills the prescription
- Other plan rules are followed

How We Cover Drugs on the PDL
The drug list has six coverage levels, called tiers. Please check your enrollment materials to find out how much you will pay for a drug on each of the tiers.

- Tier 0: These drugs are considered preventive medications under the Affordable Care Act (ACA), and we cover them at no cost to you.
- Tier 1: Drugs on this tier are usually preferred generic drugs. They will typically cost the least amount of money out of your pocket.
- Tier 2: Drugs on this tier are usually generic drugs. They will typically cost less than brand drugs.
- Tier 3: Drugs on this tier are usually preferred brand drugs. They typically cost less than other brand drugs.
- Tier 4: Drugs on this tier are usually non-preferred brand drugs. They typically cost more than other brand drugs and may have generic equivalents.
- Tier 5: Drugs on this tier are usually preferred specialty drugs that are used to treat complex conditions. They are typically very expensive.
- Tier 6: Drugs on this tier are usually specialty drugs that are used to treat complex conditions. They are typically the most expensive drugs available.

Your plan includes limits and requirements for coverage of certain drugs. These requirements and limits are listed on the PDL.

Quantity Limits and Step Therapy Requirements
Some drugs that your doctor prescribes may have quantity limits associated with them. There is a limit on the number of tablets, doses, etc. that your plan will pay for each month. Other drugs may have a step therapy requirement. This simply means that before you can buy a drug listed on the step therapy drug list, you must first have tried one or more prerequisite drugs that are also appropriate to treat your condition. If you believe that there is justification for us to forgo a particular quantity limit or step therapy requirement, you or your doctor can submit a request by calling our Health Care Services department at 800-950-5387. We will review your request and make a decision within two business days after receiving all of the necessary medical information. We will notify you of our decision by mail.

Prescriptions Requiring Prior Authorization
Some medications that your doctor prescribes may require prior approval from us before your plan will cover them. In order to get prior approval, your physician must contact our pharmacy benefit manager at 800-294-5979. A drug must meet the FDA prescribing guidelines in order for prior authorization to be approved. If your physician is prescribing a medication for an off-label indication — for example, one that the FDA has not officially approved for use — we will deny prior authorization except as required by South Carolina law in treatment of cancer. If your doctor would like for us to reconsider a prior authorization our pharmacy benefit manager denied, he or she can submit a request by calling Health Care Services at 800-950-5387. We will review the request and make a decision within two business days after receiving all of the necessary medical information. We will notify you of our decision by mail.
Specialty Drugs

Specialty drugs are prescription drugs used to treat complex or chronic conditions. This includes cancer, rheumatoid arthritis, multiple sclerosis and hepatitis, among others. Some specialty drugs can either be taken by mouth or injected by the patient themselves, or they may be given/administered in your doctor’s office. Your benefit may require certain specialty drugs be administered/given in a specific site of service. Specialty drugs may need special handling and refrigeration. Taking them sometimes requires careful monitoring.

Self-administered specialty drugs — those taken by mouth and those you inject yourself — must be purchased through the preferred specialty pharmacy vendor. Oral and self-injectable drugs have a monthly specialty pharmacy copayment.

Specialty drugs administered in the doctor’s office do not have to be purchased from the preferred specialty pharmacy vendor. Specialty drugs given in the doctor’s office have a specialty pharmacy copayment for each administration.

To see the drugs listed on the Specialty Drug List, go to our website at www.BlueChoiceSC.com, select Members then Prescription Drug Information, then Specialty Drug List, or you can contact Member Services (see the Introduction page) and request a copy. Please see your Schedule of Benefits to find your copayment amount for specialty drugs.

Additional Pharmacy Considerations

It is important to remember that we only allow prescriptions to be filled at a retail pharmacy for a one-month supply at a time. In addition, we will only pay for a one-month supply to be dispensed every 25 days. If you should need to refill a prescription early because of travel or some other emergency situation, please contact Member Services (see the Introduction page), and a one-time exception may be made. You may also be eligible for mail-service benefits, which allow you to purchase up to a 90-day supply at one time.

Can the PDL Change?
The drug list may change from time to time. Always refer to www.BlueChoiceSC.com for the most current list.

What if My Drug Is Not on the PDL?

If your drug is not on this drug list, call Member Services to make sure your drug is, in fact, not covered. If you learn we do not cover your drug, you have two choices: Ask Member Services for a list of similar drugs covered under your plan. When you get the list, show it to your doctor and ask him or her to prescribe a similar drug on the PDL. Similar drugs that are preferred may be easier to get and cost you less than non-preferred drugs. Or, ask BlueChoice to make an exception and cover your drug. We will require additional medical documentation from your physician. You or your doctor can fax a request to Caremark at 855-245-2134. To start the exception request, you can call Member Services at 800-868-2528.
If You Need Other Services

Lab Work, X-ray Studies and Pathology
Lab work, X-rays and pathology benefits vary depending on where you get these done. Services provided in your doctor’s office are generally the least expensive for you. Sometimes, your doctor may need to refer you for more specialized testing. In this case, please ask your doctor to refer you to a network provider. To minimize your out-of-pocket costs, services provided outside of a hospital setting are generally less expensive.

Vision Care
We offer vision coverage with some of our plans. To confirm coverage, check your Schedule of Benefits or contact Member Services. (See the Introduction page for contact information.)

Behavioral Health
Companion Benefit Alternatives (CBA) will coordinate behavioral health benefits if you have these benefits through us. CBA is a separate company that administers behavioral health benefits on behalf of BlueChoice. The CBA network includes a variety of mental health professionals, including psychiatrists, psychologists, licensed social workers and counselors.

To receive services from a mental health or substance abuse professional, you can contact CBA at 800-868-1032. Your doctor can also refer you to a mental health or substance abuse professional. Your doctor will handle all referrals and coordinate your care directly with CBA.

If You Need Care Away from Home

If you are traveling outside of the BlueChoice network service area and need treatment, we will cover initial treatment of emergency and urgent care. Please call 800-810-BLUE (2583) and ask for a referral to the nearest physician or urgent care center. Refer to the Emergency and Urgent Care section on pages 10 and 11 for more information. If you have an emergency, please go to the nearest health care facility.

Within the U.S.
- Always carry your BlueChoice ID card with you when you travel.
- In an emergency, go directly to the nearest hospital.
- To find nearby doctors and hospitals for urgent care, call BlueCard Access at 800-810-BLUE (2583) or visit www.BlueCard.com and select Find a Doctor or Hospital.
- Call BlueChoice for prior authorization, if necessary.

Refer to the phone number on the back of your card.
- When you arrive at the participating doctor’s office or hospital, simply present your ID card.
- You should not have to complete any claim forms or pay up front for medical services other than the usual out-of-pocket expenses (deductibles, copayments, coinsurance and non-covered services).

Follow the same simple process as in the U.S., with these exceptions:
- In most cases, you will not need to pay for inpatient care at BlueCard Worldwide hospitals. You are responsible for the usual out-of-pocket expenses (non-covered services, deductibles, copayments and coinsurance). The hospital should submit your claim.
- You will be responsible for payment when not using a BlueCard Worldwide hospital. You will need to submit an international claim form along with the bill to BlueCard Worldwide Service Center (the address is on the form). You can find the claim form at www.bcbs.com/bluecardworldwide.

Around the World
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 HealthPlan 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 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

Transition of Care Review Process
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

This review process normally takes approximately 10 business days. We will do our best to expedite this.

We will deny benefits for care received from non-participating providers after an approved transition period has expired or we will reimburse at the out-of-network benefit level.
BlueChoice HealthPlan Transition of Care
Continuation of Care Request Form
(Please use a separate form for each condition)

Employee’s Name

ID #

Address

City/State/ZIP

Effective Date

Phone: (Home) ___________________ (Work) ___________________

Patient’s Name

DOB

ID #

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
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 our allowance 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.
The amount you pay for services varies based on your plan, and you can find details in your Schedule of Benefits. Remember, you always pay less when you visit a network provider.

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

- **Copayment**: The fixed dollar amount you pay for a particular medical service. For example, if your health plan has a $20 copayment for an office visit, you would be responsible for paying $20 every time you visit the doctor.

- **Coinsurance**: The percentage of covered expenses that you must pay. For example, if your physician charges $100 for a service and your health plan has a 20 percent coinsurance payment, you would be responsible for paying $20 and we would pay $80.

- **Deductible**: The amount of medical expenses you must pay for during a particular period of time (usually a year) before we begin payment. For instance, if you have a hospital deductible of $300 for each 12-month period, you would be responsible for paying $300 worth of inpatient hospital expenses before we would begin payments.

- **Allowed Amount**: The dollar amount our network health care providers have agreed to accept as full payment. If you go to a non-participating provider, you will be responsible for all charges above the allowable amount, in addition to any deductible, copayment or coinsurance.

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

Please note: Your benefits are subject to all limitations, copayments, deductibles, coinsurance, maximum payment amounts and exclusions in your benefit plan.

**Discover My Health Toolkit**
This feature on our website provides several tools to help you estimate what you will pay for certain conditions and procedures, compare the cost of prescription drugs and more. See the web section of this guide for more details about My Health Toolkit.
**Claims, Coverage and Payment Concerns**

**EOB**
We send an EOB every few weeks for claims we process. The EOB will show a breakdown of the charges and payments for your care. It will also indicate how much of the charges you are responsible for paying. Your doctor should not bill you for more than the amount shown in the “What you owe the provider” box on your EOB. You can also access your EOBs on our website through My Health Toolkit.

**Submitting Claims**
With in-network care, you should not have to file claims. Your doctor or other participating provider will file your claims for you. If you receive out-of-network care, however, you may need to file a claim for reimbursement. All you have to do is send a copy of the doctor’s claim or statement and any supporting information to:

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

We will review the claim and determine if your benefit plan covers the service.

**If You Receive a Bill**
If you receive a bill from your doctor, check first to see if it really is a bill. Many times, you will receive a summary of services. Somewhere on the document it will say, “This is NOT a bill.”

If you do receive a bill, it should only be for the amount shown on the EOB that we sent you. If the bill is for more than this amount, please contact us. We will help you with what to do.

**COB**
We work hard to control the rising costs of health care. One way we do this is through COB. COB helps us ensure you receive all of your coverage without paying too much to the doctor. If you are covered under more than one group health plan, one plan is primary and pays first. The other plan is secondary and pays second.

For example, if BlueChoice is your secondary plan, we must receive the EOB from your primary plan before we can pay our portion of the claim.

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

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

**Attention all retirees and those on Medicare:** If Medicare is your primary health plan, we will coordinate our benefits with what Medicare has paid. Services specifically excluded from your BlueChoice benefits will not be eligible for coverage. We will reimburse any coinsurance up to 20 percent of the allowed amount that Medicare does not pay. If BlueChoice is your primary health plan, you must see a participating provider, and all routine authorization rules apply.

**Verification of Incapacitated Dependent**
At BlueChoice, we understand that you want to take care of your family, especially any adult children over age 26 who may be incapacitated. An incapacitated dependent is one who is (1) incapable of self-support because of developmental disability, mental illness or physical incapacity which began before the child reached the limiting age; and (2) mainly dependent upon you for support and maintenance. The child must have developed the handicap before he or she reached the age at which coverage would otherwise terminate. To keep coverage for an incapacitated dependent, you must give us written proof of the disability from a physician by the dependent’s 26th birthday. For the child to remain covered, we must receive a physician’s written report at least every two years. Coverage must also remain in effect for you. For incapacitated dependents, we must have a signed and completed incapacitated dependent form describing the disability and prognosis. Please note that services eligible for coverage do not change from the services the subscriber’s benefits cover.
Preventive Care and How to Stay Healthy

At BlueChoice, we care about your health. We want to do whatever we can to help you stay healthy and free from disease. Here are some ways your plan supports you in being healthy:

Coverage for Preventive Exams and Screenings
We cover routine wellness checkups and screenings from network providers. We want you to take advantage of all the preventive benefits you have for recommended screenings and exams. This includes routine checkups for children, immunizations, annual physicals, routine mammograms, cholesterol tests, routine colonoscopies and more!

Preventive Health Guidelines
We want to make sure you have access to the most current information about prevention. You can find the recommended schedule of preventive health screenings on our website. These Preventive Health Guidelines are located in the Resources section of our website, or you can contact Member Services for more information (See the Introduction page for contact information).

Great Expectations for Health Programs
Our Great Expectations for health programs help educate you about your overall health. We support you as you make healthy lifestyle changes. Whether you are already healthy and active, have a chronic condition, are pregnant or have serious health challenges, we can help you take charge of your health!

Great Expectations for health offers programs for:
- Asthma
- Back Care
- Case Management
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Children’s Health
- Childhood Obesity
- Depression
- Diabetes
- Heart Disease
- Heart Failure
- High Blood Pressure
- High Cholesterol
- Maternity
- Men’s Health
- Migraine
- Metabolic Health
- Tobacco Cessation
- Weight Management
- Women’s Health

For more information, please explore the individual programs at www.BlueChoiceSC.com. To enroll in a Great Expectations program, you can call us at 855-838-5897.
Visit With a Doctor 24/7/365!
You can now visit with a doctor faster and more easily than ever. With Blue CareOnDemand, you can visit with a doctor via smartphone, tablet or computer, rather than visiting an office or urgent care facility. Doctors will diagnose and write prescriptions as appropriate.

When Should You Use Blue CareOnDemand?
- If you should see a doctor, but can’t fit it into your schedule
- The doctor’s office is closed
- You are too sick to drive
- You have kids at home
- You are traveling

What Types of Conditions Can Blue CareOnDemand Doctors Treat?
- Colds
- Flu
- Fever
- Rash
- Pinkeye
- Ear infection
- Migraines

Don’t wait until you’re sick!
Download the app via the App Store or Google Play and sign up for Blue CareOnDemand today! Visit www.BlueCareOnDemandSC.com.

NOTE: Blue CareOnDemand is not available to members located in Texas or Arkansas. Doctors cannot prescribe medications via video to members located in Indiana.

Have You Heard About The BlueChoice HealthPlan Wire?
As a BlueChoice member, you can have health information delivered to your smartphone with The BlueChoice HealthPlan Wire, our text messaging tool. Updates include:
- How to make the most of your coverage
- Health and wellness reminders
- … and more!
To get started, simply text the word BlueTEXT to 73529 OR call 844-206-0622. Please have your member ID card ready.
Information on the Web

When you need to download forms, learn specifics about our health plans, send us emails, review the prescription drug list or read about our wellness programs, you can visit www.BlueChoiceSC.com. Our website is a protected, secure and convenient way for you to access information on your own schedule — not ours.

My Health Toolkit

You can:

- Review the status of claims
- View and print a copy of your EOB
- See how much you have paid toward your deductibles or out-of-pocket limits
- Ask Member Services a question through secure email
- Request a new ID card

In the Benefits section, you can access these features:

- Prescription Drugs
  - View prescription history
  - Find information about medications you are taking or have taken
  - Learn about potential therapeutic options to discuss with a physician
  - Compare drug costs
  - Get up-to-date information about drug benefits
- Request a replacement ID card
- Review your Eligibility and Benefits including your Schedule of Benefits

Notes: If your health plan does not have pharmacy benefits, access to prescription drugs may be limited.

In the Health and Wellness section, you can use these helpful tools:

- Personal Health Record — Track medical history, appointments, doctors, prescriptions and more
- Great Expectations for health — Enroll in one of our many programs to help you manage a disease or condition ... or just live a healthier life!
- Health Library — Browse health topics from A to Z, explore a variety of tools and calculators or find articles on first aid, common illnesses, symptoms and more
- Check Drug Interactions — Check for possible interactions with other prescriptions, food, alcohol, caffeine and more

In the Resources section, you have access to:

- Find a network health care professional or hospital within South Carolina, outside South Carolina or around the world. You can also view the professional qualifications of primary care doctors and specialists, including the medical school attended, residency completed, specialty and board certification status.
- Contribution Calculators — Use these handy tools to help determine health savings account (HSA) and flexible spending account (FSA) contributions
- Treatment Costs — Research the average costs and days of treatment for specific medical conditions and procedures
Employee Assistance Program (EAP) Services
First Sun EAP provides a broad array of services designed to help people and encourage success. Because First Sun is a separate company from BlueChoice, First Sun will be responsible for all services related to the employee assistance program. These services are free to you and those in your household.

Counseling Sessions
First Sun provides three free sessions for you and your family members, per person per contract year, for individual, couple and family counseling.

Counseling Services:
- Alcohol/Substance Abuse
- Anger Management
- Anxiety
- Depression
- Family Conflict
- Grief and Loss
- Marital/Relationship Issues
- Personal Concerns
- Stress Management
- Spiritual Concerns
- Trauma Issues
- Workplace Concerns

Life Management Services
Three free life management services are available for you and your family members, per person per contract year.

- Adult Care Resources
- Child Care Resources
- College Consultation Resources
- Financial Counseling
- Legal Services
- Parenting/Adoption Resources

Dedicated professionals are available to serve you 24 hours a day, seven days a week. Call 800-968-8143.
Policies and Procedures

In this section you will find information about many of our policies and procedures. Please read this information carefully and let us know if you have questions.

Administering Benefits for Appropriate Services
We are committed to offering the best benefits to our members. As part of this commitment, BlueChoice:

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

Appeals and External Review Procedures
You have the right to appeal decisions we make about your coverage, benefits or relationship with us. For example, you can appeal if we deny benefits for a health care service and you don’t agree with the decision. We are committed to providing you a quick resolution of your concerns. You must appeal the decision within six months of receiving the denial. You can appeal a decision by calling Member Services (see the Introduction page for contact information) or by faxing your appeal to 803-714-6443. Your appeal must include:

- Your name and identification number (as printed on your ID card)
- Information about the denial you are appealing
- Information and comments that support a review of the denial

Once we receive the information, our Appeals department will conduct a complete investigation. You will be notified of our decision in writing, within 30 days, if a denial is being given before a service occurs, or within 60 days if a service has already occurred.

There are state and federal laws that allow you to ask for an external review, in some cases, when we deny payment for a claim. These situations have different guidelines based on various things, such as whether your employer’s health care coverage is “grandfathered” or not under health care reform law. Please call our Member Services department (see the Introduction page for contact information) to find out your specific options for an external review.

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

In certain situations, after you have completed the appeal process, you may be entitled to an additional review of your claim at our expense. You may ask for an external review to reconsider your claim if we’ve denied it, either in whole or in part. The claim must have been denied, reduced or a service terminated because: 1) it doesn’t meet our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness; or 2) it is investigational or experimental. You can call or write the Member Service Center listed above to find out what the amount payable would have been. After your internal appeals are completed, we’ll notify you in writing of your right to request an external review. You should file a request for external review within four months of receiving that notice. You’ll be required to authorize the release of any medical records that may be needed for the purpose of reaching a decision during the external review.
Covering New Technology
With so many advances in medical technology and services, a policy may not be in place for a procedure or treatment made available by new technology. In this situation, we consider coverage based on a review of these types of resources:

- Recommendations from the Blue Cross and Blue Shield Association’s Technology Evaluation Center
- Results from the FDA and other government regulatory review panels
- Reviews of studies published in peer-reviewed medical journals
- Clinical reviews performed by same-specialty physicians from medical review boards external to BlueChoice

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

Questions and Concerns
If you have any questions, concerns, complaints, compliments or suggestions, please contact Member Services. If you have a question about an authorization, you must notify us within six months from the date we approved or denied the authorization. If you have any concerns about the quality of care you received, we will start a formal investigation through our Quality Improvement department.

Subrogation
BlueChoice is subrogated to your rights against a liable third party causing you injury for not more than the amount that BlueChoice has paid previously in relation to your injury by the liable third party. This means that if a liable third party causes you to be injured and the company pays your medical bills, it has the right to get the money back from the liable third party responsible for your injury or from you if they have paid it to you. If you sue the liable third party or if you accept a settlement from the liable third party, the company still has the right to get the money back. As a member of BlueChoice, you should help the company recover this money, at no expense to you. Attorney fees and costs will be paid by the company from the amounts recovered. The Director of the Department of Insurance or his designee, upon being petitioned by the policyholder, may determine that the exercise of subrogation by the company is inequitable and commits an injustice; if this determination is made, subrogation is not allowed. This determination by the director or his designee may be appealed to the Administrative Law Judge Division as provided by law.
Rights and Responsibilities
At BlueChoice, we are dedicated to being your partner in health care. We want to ensure that you receive the information you need about your health plan, the people providing your care and the services they provide. Knowing this information allows you to be an active participant in your own care. As part of this process, you need to understand your rights and responsibilities as a BlueChoice member, which are:

Member Rights
1. Members have the right to be treated with respect and recognition of their dignity and right to privacy.
2. Members have the right to choose their own personal doctor from our list of health care professionals. If members are not happy with their first choice, they have the right to choose another primary care physician from our network.
3. Members have the right to expect their primary care physician and his or her team to coordinate all the care they need.
4. Members have the right to participate with their doctors in decision-making to help take charge of their own health.
5. Members have the right to get the information they need to make a thoughtful choice before they take any treatment their doctor suggests. This includes information about the appropriateness or medical necessity of treatment options, regardless of cost or benefit coverage.
6. Members have the right to learn about their condition and treatment in words they understand and to be a part of decisions about their own care.
7. Members have the right to share their opinions, concerns or complaints constructively.
8. Members have the right to receive information about BlueChoice, our services, practitioners, providers and members’ rights and responsibilities.
9. Members have the right to complain or make appeals about BlueChoice or the care they receive.
10. Members have the right to make recommendations regarding BlueChoice’s members’ rights and responsibilities.

Member Responsibilities
1. Members have the responsibility to treat all medical staff with respect and courtesy as their partners in good health.
2. Members have the responsibility to work with their doctors to form a good relationship based on trust and team work.
3. Members have the main responsibility of keeping up their good health and preventing illness.
4. Members have the responsibility to ask questions and make sure they understand the information they receive.
5. Members have the responsibility to give BlueChoice and their doctors as much information as they can so it can be used to help them get well.
6. Members have the responsibility to work with their health care professional to understand their health problems, participate in developing a mutually agreed upon treatment plan and to follow the directions agreed on.
7. Members have the responsibility to think about what might happen if they don’t follow their doctors’ treatment plans or suggestions.
8. Members have the responsibility to keep appointments they schedule. In cases where they may have to cancel or may be running late, members have the responsibility to call the office and let them know.
9. Members have the responsibility to read all our materials carefully as soon as they sign up for BlueChoice. Members have the responsibility to follow the rules of their membership.
**Allowed Amount** - The dollar amount that a health plan determines is appropriate for a covered service. BlueChoice network health care providers have agreed to accept the allowed amount as full payment (minus applicable copayments), which means you pay less for your care.

**Authorization** - The approval of medically necessary care by a managed care or insurance company for its member.

**Benefit** - Payment provided for covered services under the terms of the policy. The benefit may be paid to the member or to others on the member’s behalf.

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

**Copayment** - A specific amount of money you pay for certain services, such as office visits or medications, each time you use that service, as defined by your plan. For example, if your health plan has a $15 copayment for an office visit, you would be responsible for paying $15 every time you visit your doctor’s office.

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

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

**Exclusions** - Specific conditions or circumstances that are not covered under the contract.

**In-Network Care** - Refers to services you receive from physicians who participate in the BlueChoice network. These are listed in your *Certificate of Coverage*. (See the Introduction page.)

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

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

**Open Access Plan** - This plan allows you to visit any doctor you choose without getting a referral from a primary care physician, whether the physician is in our network or not.

**Out-of-Network Care** - Refers to services you receive from physicians who do not participate in the BlueChoice network.

**Participating Providers** - Physicians, hospitals, skilled nursing facilities, home health agencies, hospices and other providers of medical services and supplies who agree to participate in the BlueChoice provider network.

**Primary Care Physician** - Doctors who provide primary care include pediatricians, family medicine doctors and internal medicine doctors. The physicians usually treat the whole person and may provide preventive care and routine checkups, as well as sick care or treatment of chronic illnesses.
What We Do Not Pay For

Please refer to your Certificate of Coverage on our website which can be found here for a complete list of the services your plan doesn’t cover. Services we don’t cover are called exclusions. Services with restrictions are called limitations. You will be responsible for payment of non-covered services.

You are responsible for paying the provider’s bills when you do NOT use a BlueChoice network provider. The only exception to this is emergency or urgent care.

Services and Supplies We Don’t Cover

We don’t provide benefits for these items unless otherwise specified in the Schedule of Benefits. We will not deny treatment of an injury this policy generally covers if the injury results from being a victim of an act of domestic violence.

Excluded Services

Except as specifically provided in this policy, even if medically necessary, no benefits will be provided for:

- Services for which no charge is normally made in the absence of insurance.
- Services or supplies for which you are entitled to benefits under Medicare or other government programs (except Medicaid).
- Injuries or diseases paid by Workers’ Compensation or settlement of a Workers’ Compensation claim.
- Treatment provided in a government hospital that you are not legally responsible for.
- Rest care or custodial care.
- Illness contracted or injury sustained as the result of: war or act of war (whether declared or undeclared), participation in a riot or insurrection, service in the armed forces or an auxiliary unit.
- Treatment, services or supplies received as a result of suicide, attempted suicide or intentionally self-inflicted injuries unless it results from a medical (physical or mental) condition, even if the condition is not diagnosed prior to the injury.
- Any plastic or reconstructive surgery done mainly to improve the appearance or shape of any body part and for which no improvement in physiological or body function is reasonably expected, also known as cosmetic surgery. Cosmetic surgery includes, but is not limited to, surgery for saggy or extra skin (regardless of reason); any augmentation, reduction, reshaping or injection procedures of any part of the body; rhinoplasty, abdominoplasty, liposuction and other associated types of surgery; and any procedures using an implant that doesn’t alter physiologic or body function or isn’t incidental to a surgical procedure. Cosmetic surgery does not include reconstructive surgery incidental to or following surgery resulting from trauma, infection or other diseases of the involved part. Complications arising from cosmetic surgery are also not covered.
- Eyeglasses, contact lenses (except after cataract surgery), except as shown in the pediatric vision sections, and hearing aids and exams for the prescription or fitting of them. Any hospital or physician charges related to refractive care such as radial keratotomy (surgery to correct nearsightedness), or keratomileusis (laser eye surgery or LASIK), lamellar keratoplasty (corneal grafting) or any such procedures that are designed to alter the refractive properties of the cornea.
- Services, care or supplies used to detect and correct, by manual or mechanical means, structural imbalance, distortion or subluxation in your body for the purpose of removing nerve interference and its effects when this interference is the result of or related to distortion, misalignment or subluxation of, or in, the spinal column.
- Services and supplies related to non-surgical treatment of the feet, except when related to diabetes.
Physician services directly related to the care, filling, removal or replacement of teeth; the removal of impacted teeth; and the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. This includes, but is not limited to: apicoectomy (dental root resection), root canal treatment, alveolectomy (surgery for fitting dentures) and treatment of gum disease. Exception is made as shown in the pediatric vision sections, for dental treatment to sound natural teeth for up to six months after an accident and for medically necessary cleft lip and palate services.

Separate charges for services or supplies from an employee of a hospital, laboratory or other institution; or an independent health care professional whose services are normally included in facility charges.

Hospital or skilled nursing facility charges when you don’t get prior authorization.

Services and supplies that are not medically necessary, not needed for the diagnosis or treatment of an illness or injury or not specifically listed in Covered Services.

Services and supplies you received before you had coverage under this policy or after you no longer have this coverage, except as described in Extension of Benefits under Eligibility in the When Your Coverage Ends section of this policy.

For a complete list of exclusion and limitations, please review the Certificate of Coverage which can be found here on our website for your health plan.
Authorization to Disclose Protected Health Information (PHI) to a Third Party

PLEASE RETURN THIS FORM TO: BlueChoice HealthPlan of South Carolina, Inc., Attn: Privacy Officer (AX-400), P.O. Box 6170, Columbia, SC 29260-6170. Fax number 803-714-6443.

SECTION 1. MEMBER INFORMATION. (INDIVIDUAL WHOSE INFORMATION MAY BE DISCLOSED)
Name: ___________________________ Date of Birth: ____________ Telephone: ____________
Address: ____________________________
Primary Member’s ID Number or Social Security Number: ____________________________
Spouse’s Name (if included in authorization): ____________________________ Date of Birth: ____________
Dependent’s Name, Age 16 or Older (if included in authorization): ____________________________
Dependent’s Name, Under Age 16 (if included in authorization): ____________________________

SECTION 2. AUTHORIZED INDIVIDUAL/ENTITY. (PERSON OR ORGANIZATION RECEIVING YOUR INFORMATION)
I authorize BlueChoice HealthPlan to disclose my PHI to:
Name: ____________________________ Relationship: ____________________________
Address: ____________________________ Telephone: ____________________________
Name: ____________________________ Relationship: ____________________________
Address: ____________________________ Telephone: ____________________________

SECTION 3. DESCRIPTION OF INFORMATION TO BE RELEASED. (TYPE OF INFORMATION THAT WILL BE USED OR DISCLOSED.)
Please check only one:
☐ I authorize BlueChoice HealthPlan to disclose any of my PHI (except psychotherapy notes) that the above-named individual/entity may request. I understand the information may include information pertaining to chronic diseases, behavioral health conditions and communicable diseases, including HIV or AIDS and/or genetic information.
☐ Also include any alcohol and substance abuse records, if applicable. (Indicate by initialing)
☐ This authorization will not apply to alcohol or substance abuse information unless specifically authorized.
☐ I authorize BlueChoice HealthPlan to disclose ONLY the following PHI: ____________________________
This authorization is made at my request or for this purpose(s):

SECTION 4. EXPIRATION AND REVOCATION. (WHEN THIS AUTHORIZATION WILL END)
Expiration: This authorization will expire 12 months after termination of my coverage under BlueChoice HealthPlan or on __/__/____, whichever occurs first.
Revocation: I understand that I may revoke this authorization by sending written notice of my revocation to the address shown above. I understand that revocation of this authorization will not affect any action taken by BlueChoice HealthPlan on this authorization before my written notice of revocation was received.

SECTION 5. SIGNATURE.
I am making this authorization voluntarily and have had full opportunity to read and consider the contents of this authorization. I understand that BlueChoice HealthPlan will not condition my enrollment in a health plan, eligibility for benefits or payment of claims upon my signing this authorization. I further understand the Authorized Individual/Entity may not be subject to federal/state privacy laws and they may further release my PHI.
Signature: ____________________________ Date: ____________________________
Spouse’s Signature: ____________________________ Date: ____________________________
Dependent Age 16 or Older Signature: ____________________________ Date: ____________________________
Dependent Age 16 or Older Signature: ____________________________ Date: ____________________________

If the individual’s legal Personal Representative is completing this authorization, the Personal Representative must sign below and attach legal documentation that establishes his or her authority to act on the individual’s behalf.

Personal Representative’s Printed Name/Signature: ____________________________

You should keep a copy of this signed authorization for your records; however, we will provide you a copy upon your request.

Auth (Rev. 9/2015)
NOTICE OF OUR PRIVACY POLICIES AND PRACTICES

This Notice has been prepared to inform you that we do not disclose, and we reserve no right to disclose, to our affiliates or to nonaffiliated third parties any nonpublic personal financial information about you that we collect and maintain, except as described in this notice. We will treat information about you in accordance with this Notice even after our customer relationship ends. We may disclose any information we collect about you as necessary to provide our products and services to you. We may also disclose any information about you to third parties that perform services on our behalf, with your permission or as otherwise permitted by law.

If you are a plan sponsor or group policyholder, this Privacy Notice describes our practices for safeguarding nonpublic personal financial information about employee benefit plan participants and beneficiaries.

Information we collect and maintain: We collect information about you from the following sources:

- Information we receive from you on applications or on other forms
- Information we obtain from your transactions with us, our affiliates or others
- Information we receive from consumer-reporting agencies

How we protect information: We restrict access to information about you to our employees who need to know the information to provide our products and services to you and as permitted by law. We maintain physical, electronic and procedural safeguards that comply with applicable legal requirements to guard your nonpublic personal financial information. We have installed usernames, passwords and other safety features on our web applications to help ensure that the information about you that we collect and maintain remains safe and secure.

Changes to this Notice: We may amend our privacy policies and practices at any time, and we will inform you of any material changes as required by law.

YOU DO NOT NEED TO DO ANYTHING IN RESPONSE TO THIS NOTICE. THIS NOTICE IS MERELY TO INFORM YOU ABOUT OUR PRIVACY POLICIES AND PRACTICES.

An independent licensee of the Blue Cross and Blue Shield Association.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Privacy Promise

We understand the importance of handling your medical information with care. We are committed to protecting the privacy of your medical information. State and federal laws require us to make sure that your medical information is kept private. Federal law requires that we provide you with this Notice of Privacy Practices, which describes our legal duties and privacy practices with respect to your medical information and your legal rights with respect to our use and disclosure of your medical information. We are required by law to follow the terms of the Notice currently in effect. This Notice is effective September 23, 2013, and will remain in effect until it is changed or replaced.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as the law allows. These changes will be effective for all medical information that we keep, including medical information we created or received before we made the changes. When we make a material change to our privacy practices, we will provide a copy of a new notice (or information about the changes to our privacy practices and how to obtain a new notice) in a mailing to members who are covered under our health plans at that time.

Uses and Disclosures of Medical Information

Treatment, Payment, Health Care Operations
We may use and disclose your medical information for purposes of treatment, payment and health care operations.

Treatment: We may disclose your medical information to a physician or other health care professional to help him or her provide your treatment.

Payment: We may use or disclose your medical information for these and other activities related to payment:
- Paying claims from physicians, hospitals and other health care providers.
- Obtaining premiums.
- Issuing explanations of benefits to the named insured.
- Providing information to health care professionals or other entities that are bound by the federal Privacy Rules for their payment activities.

Health Care Operations: We may use or disclose your medical information in the normal course of conducting health care operations, including such activities as:
- Quality assessment and improvement activities.
- Reviewing the qualifications of health care professionals.
- Compliance and detection of fraud and abuse.
- Underwriting, enrollment and other activities related to creating, renewing or replacing a plan of benefits. We may not, however, use or disclose genetic information for underwriting purposes.
- Providing information to another entity bound by the federal Privacy Rules for its health care operations, in limited circumstances.

You and Your Family and Friends
We may use and disclose your medical information to communicate with you for purposes of customer service or to provide you with information you request. We may disclose your medical information to a
family member, friend or other person to the extent necessary for him or her to assist with your health care or payment for your health care. Before we disclose your medical information to that person, we will give you a chance to object to us doing so. If you are not available, or if you are incapacitated or in an emergency situation, we may, in the exercise of our professional judgment, determine whether the disclosure would be in your best interest. We may also use or disclose your medical information to notify (or help notify, including identifying and locating) a family member, a personal representative or other person responsible for your care of your location, general condition or death.

Your Employer or Organization Sponsoring Your Group Health Plan
We may disclose summary information and enrollment information to your employer (or other plan sponsor). Summary information is a summary of the claims history, claims expenses or types of claims that members of your group health plan have filed. The summary information will not include demographic information about you or others in the group health plan, but your employer or plan sponsor may be able to identify individuals from the summary information provided.

Disaster Relief
We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit
We may use or disclose our members’ medical information as authorized by law for the following purposes that are in the public interest or benefit:

- As required by law.
- For public health activities, including disease and vital statistics reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury.
- To report adult abuse, neglect or domestic violence.
- To health oversight agencies.
- In response to court and administrative orders and other lawful processes.
- To law enforcement officials in response to subpoenas and other lawful processes concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies and to identify or locate a suspect or other person.
- To coroners, medical examiners and funeral directors.
- To organ procurement organizations.
- To avert a serious threat to health or safety.
- In connection with certain research activities. To the military and to federal officials for lawful intelligence, counterintelligence and national security activities.
- To correctional institutions regarding inmates.
- As authorized by state workers’ compensation laws.

Your Authorization
We may not use or disclose your medical information without your written authorization, except as described in this notice. You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it at any time by notifying us of your revocation in writing. Your revocation will not affect any use or disclosure permitted by the authorization while it was in effect. We need your written authorization to use or disclose psychotherapy notes, except in limited circumstances such as when a disclosure is required by law. We also must obtain your written authorization to sell your medical information to a third party or, in most circumstances, to send you communications about products and services. We do not need your written authorization, however, to send you communications about health-related products or services, as long as the products or services are associated with your coverage or are offered by us.

Individual Rights

An Independent licensee of the Blue Cross and Blue Shield Association
P.O. Box 6170 Columbia, SC 29260-6170 BlueChoiceSC.com
You have certain rights with respect to the medical information we maintain about you. To exercise any of these rights or to obtain more information about these rights (including any applicable fees), contact us using the information listed at the end of this notice.

Access
You have the right to inspect or receive a paper or electronic copy of your medical information, with some exceptions. To inspect or receive your medical information, you must submit the request in writing. If you request to receive a copy of your records, we are allowed to charge a reasonable, cost-based fee.

Disclosure Accounting
You have the right to request, in writing, a record of instances in which we (or our business associates) disclosed your medical information for purposes other than treatment, payment, health care operations, and as allowed by law. We will provide you with a record of such disclosures for up to the previous six years. If you request a record of disclosures more than once in a 12-month period, we may charge you a reasonable, cost-based fee for each additional request.

Restriction
You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your medical information. By law, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions will be made in writing and signed by a person authorized to make such an agreement for us.

Confidential Communications
You have the right to request, in writing, that we communicate with you about your medical information by other means, or to another location. We are not required to agree to your request unless you state that you could be in danger if we do not communicate to you in confidence. In that case, we must accommodate your request if it is reasonable, if it specifies the other means or location, and if it permits us to continue to collect premiums and pay claims under your health plan. We will not be bound to your request unless our agreement is in writing.
Even if we agree to communicate with you in confidence, an explanation of benefits we issue to the named insured for health care services the named insured (or others covered by the health plan) received might contain sufficient information (such as deductible and out-of-pocket amounts) to reveal that you obtained health care services for which we paid.

**Amendment**
You have the right to request, in writing, that we amend your medical information. Your request must explain why we should amend the information. We may deny your request if we did not create the information you want amended and the person or entity that did create it is available, or we may deny your request for certain other reasons. If we deny your request, we will send you a written explanation.

**Notice of Breach**
We are required to notify affected individuals following a breach of unsecured medical information.

**Electronic Notice**
You may request a written copy of this notice at any time or download it from our website.

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**Questions and Complaints**
If you want more information about our privacy practices, or if you have questions or concerns, please contact us using the information below.

If you believe we may have violated your privacy rights, you may submit a complaint to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with that address upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**Contact Information**
Attn: Bruce Honeycutt, Privacy Officer
120 East @ Alpine Road (AX-E01)
Columbia, SC 29219

803-264-7258 (telephone)
803-264-7257 (fax)
Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you’re assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hrcs.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyon tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugan ito, may karapatan ka na makakuhang ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makuasa ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعدته أسئلة بخصوص خطة الصحة هذه، فليس لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل ب 911.396-3944. (Arabic)
Si ou memn oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfomasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu’un que vous êtes en train d’aider, avez des questions à propos de ce plan médical, vous avez le droit d’obtenir gratuitement de l’aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سوالاتی درباره این برنامه بهداشتی داشته باشید، حق این را دارید که مک اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با متراجم، لطفاً با شماره 333-623-398-44-811 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t’áá háída bíká’aná nílwo’igii dií Bécso Ách’ágh naa’níligí háá’ida yí na’ íd’il kidgo, níhá’áhóó’ti’i’ níhí ká’a’doo woñgo kwii hi’át’ishíí bi na’idokidigi doo bíc’e’azlāagōó. Ata’ halnc’e’ la’ bích’i’ ha desdziih ninizingo, kojí’ béésh bee hólne’ 1-844-516-6328. (Navajo)

Rvs 3/13/2017 2 19199-3-2017
If you need an interpreter, we have free services available for both oral and written assistance. If you have questions about your coverage, please contact Member Services for more information. We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.