Plan 4

How Your Benefits Work

Your Guide to BlueChoice HealthPlan Services

BlueChoice for Kids.
Keeps *kids* moving.
www.BlueChoiceSC.com

BLUECHOICE HEALTHPLAN
BlueCross BlueShield of South Carolina

Table of Contents

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

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

Visit our Web site:
www.BlueChoiceSC.com

Write to us:
BlueChoice HealthPlan
Member Services
P.O. Box 6170
Columbia, SC 29260-6170

Or call Monday through Friday between 8:30 a.m. and midnight:
(803) 786-8476 In Columbia
1-800-868-2528 Outside of Columbia

Learning About Your Health Plan

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

What We Pay For

- To receive payment from us, a service must be medically necessary and listed as a covered service in your Schedule of Benefits or Certificate of Coverage. Payment is provided for covered services you receive while you are enrolled as a member of BlueChoice HealthPlan.
- Your primary care physician will provide most of the services you receive. If you receive services from another health care professional, your primary care physician and BlueChoice HealthPlan must approve the services before you receive them in order for them to be paid. The only exceptions are if you require emergency or urgent care. If your physician refers you to another health care professional participating in the BlueChoice HealthPlan network, he or she will contact us to obtain approval. If you are unsure whether BlueChoice HealthPlan has approved a service, please contact Member Services.
- The benefits provided by your plan may be different from the benefits of another plan. To see exactly what services are covered under your plan, please check your Schedule of Benefits or Certificate of Coverage.

What We Do Not Pay For

- Please refer to your Certificate of Coverage for a list of the services not covered under your plan. Services not covered are called "exclusions," while services with restrictions are called "limitations." If you receive a service that falls under one of these categories, you will be responsible for payment of the resulting charges.
- You are responsible for paying the physician's bills when you do not receive approval from your primary care physician and BlueChoice HealthPlan before you receive a service. The only exception to this is emergency or urgent care.

Schedule of Benefits – Plan 4

In order to receive benefits, all care must be provided by the member's primary care physician or authorized in advance by the primary care physician and the company, unless otherwise noted. This applies to each and every individual service or treatment unless otherwise noted. Benefits are subject to all terms, conditions, limitations, exclusions and maximums in this contract.

Deductible, per Benefit Period	$1,500	
Maximum Coinsurance per Benefit Period	$5,000	
Benefits	**Member Pays**	**Plan Pays** *after copayment/ deductible*
Physician Services		
Primary Care		
Office services	$25 copayment per visit	100%
Hospital Services	$0	100%
Specialty Care		
(except mental health/substance abuse care)		
Office services	Deductible, then 30%	70%
Hospital services	Deductible, then 30%	70%
Outpatient Mental Health Benefits	$25 per visit; 20 visits per Benefit Period	100%
Other Services		
Rehabilitation services	Deductible, then 30%	70%
Ambulance	Deductible, then 30%	70%
Home health	Deductible, then 30%	70%
OP private duty nursing	Deductible, then 30%	70%
Hospice	Deductible, then 30%	70%
Prosthetic devices and Durable Medical Equipment	Deductible, then 30%	70%
Medical supplies	Deductible, then 30%	70%
Facility Services		
Inpatient Hospital	Deductible, then 30%	70%
Skilled Nursing Facility & Long Term Acute Care Facility	Deductible, then 30%	70%
Outpatient services	Deductible, then 30%	70%
Urgent care services - for services provided by a participating urgent care center	$50 copayment per visit	100%
Emergency room services	Deductible, then 30%	70%
Dental Services		
One Exam per Benefit Period	100% after $20	$20
One Cleaning per Benefit Period	100% after $30	$30
Vision Exam		
One complete eye exam for glasses per Benefit Period	$0	100%

Benefits	Member Pays	Plan Pays *after copayment/ deductible*
Prescription Medication		
Generic Drugs	$8	100%
Preferred Drugs	$30	100%
Non-Preferred Drugs	$60	100%
Retail Pharmacy: Prescription Medications are each subject to one copayment for up to a 31-day supply. **Mail-order Pharmacy:** Prescription Medications are each subject to two copayments for up to a 90-day supply. Not all medications are available from the mail-order pharmacy.		
Specialty Pharmaceuticals		
(Not subject to the Prescription Medication Maximum)	$100 copayment per 31-day supply	100%
	Plan Maximums	
Lifetime Benefit Maximum	$1,000,000	
Prescription Medication	$2,000 per Benefit Period	
Durable Medical Equipment	$5,000 per Benefit Period	
Transplants		
(Covered Transplants)	*Maximum Benefit per Transplant*	
Kidney (single)	$ 60,000	
Pancreas/Kidney	$ 80,000	
Heart	$ 120,000	
Lung (single)	$ 130,000	
Liver	$ 225,000	
Pancreas	$ 80,000	
Heart/Lung	$ 175,000	
Lifetime Transplant Maximum Benefit	$250,000	

Your Primary Care Physician

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

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

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

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

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

If you would like information about a physician, including his or her qualifications and title, please call 1-800-327-3183 and ask for the Credentialing department.

When You Need to See a Specialist

If you need services from a health care provider other than your primary care physician, he or she may recommend that you see a participating specialist. If your primary care physician refers you to a specialist, you'll get an authorization form for that office visit. You will then have approval for benefits that are included in your health plan.

If you see a specialist without first receiving approval from your primary care physician and BlueChoice HealthPlan, the services you receive will not be paid for, even if they are medically necessary. This is the case even if you were a patient of the specialist before you became a BlueChoice HealthPlan member. In order to ensure payment by BlueChoice HealthPlan, please consult your primary care physician before receiving services. You'll prevent unnecessary medical expense and your primary care physician will be up-to-date on the care you receive.

Other Health care Providers

There may be times when you need services from another health care provider, such as a physical therapist. In this case, your primary care physician will give you approval for a certain number of visits or period of time (e.g., four visits or six months). BlueChoice HealthPlan will only pay for the visits that fall within this approved limit.

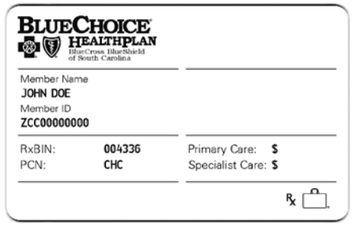
Other participating health care providers include physicians, hospitals, skilled nursing facilities, home health agencies, hospices and other providers of medical services and supplies who agree to be a part of the BlueChoice HealthPlan network. To obtain benefits for services from any of these providers, you'll need to get a referral from your primary care physician or authorized specialist.

Gynecologist (GYN)

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

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

Using Your Member ID Card



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

Your identification card is specific to your health plan. Not all of the information below will apply to you or appear on your card.

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

- *ID:* Your BlueChoice HealthPlan identification number.
- *Primary Care:* This number is your office visit copayment amount for primary care visits.
- *Specialist Care:* This number is your office visit copayment amount for specialist visits.
- *Rx Copayments:* These numbers are your copayment amounts for prescription drugs at a participating pharmacy. They represent generic/preferred brand/non-preferred brand copayment amounts.
- *Deductible:* This number is your deductible amount. *(See the glossary for more information.)*
- *ER Copayments:* This number is your copayment amount for emergency room visits.
- *Urgent Care:* This number is your copayment amount for urgent care visits at a participating urgent care facility.
- *Suitcase:* The suitcase logo indicates that you have BlueCard® coverage. If you are traveling and need medical care, the office staff will recognize this suitcase and file your claim.

Routine Visits

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

Emergency and Urgent Care

Emergency Care: There may be times when you need emergency care. BlueChoice HealthPlan encourages you to call your primary care physician, if possible, before you seek care in an emergency situation. He or she knows your medical history and is available to you 24 hours a day, seven days a week.

> *If it is not possible to call your personal physician, or delaying medical care would make your condition dangerous, please go to the nearest emergency center. If you can't get there on your own, call 911 for assistance. If your area doesn't have 911 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 primary care physician, BlueChoice HealthPlan will review your case carefully. Please realize that you may be responsible for payment if you receive emergency services that do not meet the guidelines of your plan.

Please review the following information before an emergency occurs so you'll understand your health plan benefits. More information about coverage for emergency care may be found in your *Schedule of Benefits* or *Certificate of Coverage*.

Examples of situations that are **not** considered an emergency include:

- Drug refills
- Removal of stitches
- Work excuses
- 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 that you have had for 24 to 48 hours or longer such as a cough, sore throat, rash or stuffy nose. You should call your primary care physician concerning these conditions.

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; and/or
- Serious damage to any organ or body part.

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

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

Following emergency care, contact your primary care physician so that he or she can coordinate all follow-up care. For example, if you go to the emergency room and get stitches, your primary care physician should remove them when it's time.

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

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

- Deep cut to the skin
- Severe diarrhea *(without bleeding or dehydration)*
- Earache
- 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 primary care physician or wait until normal office hours, benefits may be available for services provided at a *participating* urgent care center. Refer to your *Schedule of Benefits* to determine if urgent care services are covered under your plan. If they are, you may refer to the BlueChoice HealthPlan provider directory for a list of participating urgent care centers.

Lab Work, X-rays and Pathology

It is important to know that where lab work, X-rays and pathology are performed can affect the amount of your copayment. If your physician recommends that you receive one of these services, remind him or her that you are a BlueChoice HealthPlan member and there is a BlueChoice HealthPlan approved facility you should use.

Prescription Drugs

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

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

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

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

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

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

Specialty Pharmaceuticals: Some prescription drugs are covered under the Specialty Pharmaceuticals benefit. These are drugs that treat complex medical conditions. They include – but are not limited to – intravenous (I.V.) drugs for chronic diseases, injectable and self-injectable drugs for acute and chronic diseases and other oral drugs.

If you need a drug included in the Specialty Pharmaceuticals benefit, your physician will arrange for you to get it in one of two ways. Your physician will either administer the drug while you are in the office, or contact our vendor to get the medication for you to use at home. Specialty Pharmaceutical medications are not available for coverage through your local pharmacy.

When you receive one of these medications, you will be charged a copayment for each 31-day supply. If you have any questions about Specialty Pharmaceuticals or would like a list of the drugs included in this benefit, please contact Member Services by visiting www.BlueChoiceSC.com or by calling 1-800-868-2528.

Vision Care

If your benefit plan includes vision coverage through BlueChoice HealthPlan:

- Benefits are shown on your *Schedule of Benefits*. If you are not sure whether you have vision coverage, you may contact Member Services.
- To use your vision benefits, select a participating vision care provider. Schedule an appointment for an eye exam, making sure you identify yourself as a BlueChoice HealthPlan member. If you are going for a routine eye exam, you do not need a referral from your primary care physician.
- You may use your eyeglasses benefit as a credit toward a contact lens package from a participating vision care provider.

Behavioral Health

On behalf of BlueChoice HealthPlan, Companion Benefit Alternatives coordinates benefits for mental health and substance abuse services. CBA is a separate comppany. The CBA network includes a variety of mental health professionals, including psychiatrists, psychologists, licensed social workers and counselors.

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

When You Travel

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

Anytime you will be away for at least 90 days, you can become a guest member of an affiliated BlueCross BlueShield health plan near your destination. Just call BlueChoice HealthPlan and explain your situation. We'll find the health plan near your travel location and have you complete a guest membership application. When you arrive at your destination, all you have to do is call the number we've provided to contact the health plan. A customer service representative will provide you with the information you need, including a list of doctors and benefits available to you.

What happens if you're outside the BlueChoice HealthPlan service area and need medication? Most major chain pharmacies participate in our pharmacy network. The back of your membership identification card has a telephone number that the pharmacist may call to verify your coverage. You have the same benefits when traveling as you have when you visit your local pharmacy. If you are outside of our service area and use a non-participating pharmacy, benefits are provided only for covered prescription drugs that you need following covered emergency or urgent care.

What You Pay

Your financial responsibility depends on your individual health plan. The amount you pay for services can be found in your *Schedule of Benefits*. Below are the different payment categories for which BlueChoice HealthPlan members may be responsible.

Take a minute to look over these terms so that 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 that you must pay for an office visit, prescription or particular medical service. For example, if your health plan has a $15 copayment for an office visit, you would be responsible for paying $15 every time you visit the doctor.
- ***Coinsurance:*** The percentage of covered expenses that you must pay. For example, if your physician charges $100 for a service and your health plan has a 20% coinsurance payment, you would be responsible for paying $20 and we would pay $80.
- ***Deductible:*** The amount of medical expenses that you must pay for during a particular period of time *(usually a year)* before certain benefits payable by BlueChoice HealthPlan become effective. For instance, if your health plan has a $200 deductible for each 12-month period, you would be responsible for paying $200 worth of medical services within the 12 months before BlueChoice HealthPlan would begin payments.

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

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

Explanation of Benefits

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

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

Note: You will not receive an EOB after visiting your primary care physician. If you would like to print a copy of an EOB resulting from a visit to your primary care physician, just go to My Insurance Manager at www.BlueChoiceSC.com.

If You Receive a Bill

If you receive what looks like a bill and you followed BlueChoice HealthPlan's referral and approval process, 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 Explanation of Benefits that we sent you. If the bill is for more than this amount, please contact BlueChoice HealthPlan immediately. We will check to make sure that you saw a BlueChoice HealthPlan participating provider, address the situation if necessary and notify you of the outcome.

Coordination of Benefits

BlueChoice HealthPlan works hard to control the rising costs of medical care. One way we do this is through Coordination of Benefits (COB). How does COB work?

If an individual is covered under more than one group health plan, we refer to the different plans as either primary or secondary. The primary health plan is responsible for paying on your medical claim first, while the secondary plan pays only after the primary has paid.

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

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

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

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

Your Health Is Important to Us

Preventive Health Guidelines

Prevention is about staying healthy and free from disease. At BlueChoice HealthPlan, we believe we are here to help you reach these important goals. We want you to have the most current information about prevention. You can find the recommended schedule of preventive health screenings at www.BlueChoiceSC.com. These Preventive Health Guidelines are located in the Health and Wellness section of our Web site, or you may contact Member Services to obtain a copy.

Great Expectations®† *for health*

BlueChoice HealthPlan is more than just a health benefits plan. We have programs targeting many specific health concerns. These programs are designed to help you make lifestyle choices that may improve your health. Offered only to BlueChoice HealthPlan members, the programs are either free of charge or have a small, one-time fee. Following is a list of our programs:

- Asthma
- Case Management
- Children's Health
- Chronic Kidney Disease
- COPD
- Depression
- Diabetes
- Heart Disease
- Heart Failure
- Maternity
- Men's Health
- Migraine
- Quit Smoking
- Weight Management
- Women's Health

For more information about any of these programs, please call 1-800-327-3183, extension 25541, or visit the Health and Wellness section of our Web site at www.BlueChoiceSC.com.

Using Our Web Site

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

My Insurance Manager

- Review the status of your claims
- View and print a copy of your Explanation of Benefits
- See how much you've paid toward your deductible or out-of-pocket limit
- Ask a customer service question through secure e-mail
- Request a new ID card or change your primary care physician
- Access My Pharmacy Manager

My Pharmacy Manager

- View an electronic record of your prescription history
- Find consumer information about different medications
- Get information about potential therapeutic options to discuss with your physician
- Get cost comparison information
- Get up-to-date information about your drug benefits

If you don't have the pharmacy benefit as part of your health coverage, you'll have limited access to My Pharmacy Manager.

You will need to complete a simple registration process the first time you use My Insurance Manager. Just go to www.BlueChoiceSC.com, find "My Insurance Manager/Members" and click on the word "Now." On the next screen that appears, click on the link, "New Users: Create a Profile" and follow the prompts. Remember to write down your username and password for future reference.

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

Remember, our Web site is *safe*. Your private information stays that way. It's secure. Only you have access to any sensitive information about your health coverage. It's simple. Just a few keystrokes and mouse clicks and you've got the information you need.

Using Our Automated Telephone Features

If you prefer to contact us by telephone, you can do so through our automated telephone system. Just dial 1-800-868-2528. When the automated operator answers, follow the prompts, entering your BlueChoice HealthPlan member identification number. Then continue following the instructions for your desired function as listed below:

Press 1 for referral information

Press 2 for claims status information

Press 3 for eligibility and benefits information

Press 4 for away from home care guest membership information

Press 5 to select or change your primary care physician by using our automated attendant

Press 6 to request handbooks, directories and member literature

Press 7 to obtain emergency services information

Press 0 to speak with a Member Services representative

Administering Benefits for Appropriate Services

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

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

Covering New Technology

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

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

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

Quality Improvement

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

Rights and Responsibilities

At BlueChoice HealthPlan, we are dedicated to being your partner in health care. We want to ensure 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 HealthPlan member. To view a listing of these rights and responsibilities, please visit the Benefits Information Center on our Web site at www.BlueChoiceSC.com. If you would like to obtain a copy, you may contact Member Services.

Questions and Concerns

If you have any questions or concerns, please contact Member Services. The address and phone numbers can be found on page one. 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.

Appeals

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

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

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

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

External Review Procedures

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

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

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

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

Request for Medical Review – Prescription Quantity Limits

If you reach the maximum allowed amount of a prescription drug, you may request that we review your case. Just call Member Services or have your prescribing physician call or fax the request to us. If you decide, before reaching the maximum allowed amount, that a prescribed drug has a limit that you may need to exceed, your prescribing physician may call or fax a request to override the maximum allowed amount.

This does not apply to medications that your doctor fails to get required prior approval for, drugs that are not covered/not included in the pharmacy benefit or discount drugs *(4th tier)*. Physicians and pharmacists who are on the BlueChoice HealthPlan Pharmacy and Therapeutics Committee usually decide the maximum allowed amounts of prescription drugs, basing their decision on Food and Drug Administration guidelines.

A review request may be verbal or written. If you contact Member Services to ask for a review, you will need to provide the following information:

- Your name and BlueChoice HealthPlan identification number
- Information about the medication *(e.g., name, dosage, quantity)*, and
- Medical information from your physician on his or her letterhead that supports your request for medical review.

We will review your request and make a decision within two business days after receiving all of the necessary medical information. You will be notified of our decision by mail.

To contact us for a Medical Review, have your prescribing physician call 1-800-950-5387 or fax your request to (803) 714-6463 *(in Columbia)* or 1-800-610-5685 *(outside of Columbia)*.

Submitting Claims

With Referred Care, you should not have to file claims. Your personal physician or other participating provider will file your claims for you. However, if you receive Self-Referred Care or medical care outside of the BlueChoice HealthPlan service area, you may need to file a claim to ask for reimbursement. All you have to do is send a copy of the doctor's claim or statement and any supporting information to:

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

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

Privacy Practices

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

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

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

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

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

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

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

Copayment – Fixed dollar amount that the member must pay for an office visit, a prescription, or a particular medical service. For example, if your health plan has a $15 copayment for an office visit, you would be responsible for paying $15 every time you visit your doctor's office.

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

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

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

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

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

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

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

Primary Care Physician – Personal physician the member selects from the BlueChoice HealthPlan network of participating providers to provide or arrange for their health care needs.

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

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

Your Important Health Care Information

Name _____ Member ID Number _____

Primary Care Physician _____ Phone _____

Pharmacy _____ Phone _____

_____

_____

Name _____ Member ID Number _____

Primary Care Physician _____ Phone _____

Pharmacy _____ Phone _____

_____

_____

Name _____ Member ID Number _____

Primary Care Physician _____ Phone _____

Pharmacy _____ Phone _____

_____

_____

Hospital _____ Phone _____

Poison Control _____ Phone _____

Other Emergency Information _____

_____

_____

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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.

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 online at contact@hcrcompliance.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，請撥電話 [在此插入數字 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 đở 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 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap 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 تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon 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, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 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 سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)