Blue Option℠
Transparency in Coverage

A. Out-of-network Liability and Balance Billing

- Benefits are provided in network only. This policy requires you to use our network providers in the Blue Option Network. Benefits are covered in network only. To find a network provider, go to http://printadirectory.thesolutionsgroup.com/?source=BOE.
- No benefits are provided for services received out of network unless the service is due to an emergency or the service is not available at a network provider.

  If an enrollee has an emergency medical condition and is treated in an emergency room at an out-of-network hospital, we will provide benefits at the in-network benefit amount. The allowed amount we pay for emergency services by an out-of-network provider will be the greater of:

  a) The median amount if such emergency services were rendered by an in-network provider participating in the Blue Option Network; or

  b) The amount for those emergency services calculated using Medicare allowances, which is the method we generally use to determine payment to an out-of-network provider.

- An enrollee may be balance billed by an out-of-network provider. An out-of-network provider can balance bill for the difference between the allowed amount we pay and his or her actual charge. Balance billing is the process used when a provider bills an enrollee for the difference between the provider's billed charge and the allowed amount we pay or for the penalties for not getting authorization. For example, if the provider's billed charge is $100 and the allowed amount we pay is $70, the provider may bill the enrollee for the remaining $30. A network provider may not balance bill an enrollee for covered services.

B. Enrollee Claims Submission

- Once enrolled, if you receive health care services or supplies from a network provider, the provider will file your claims for you. If an out-of-network provider is authorized to provide services, you may be required to pay up front for the services and submit a member claim form for reimbursement. You can contact Member Services if you have any questions or need to file a claim.
- All claims must be submitted within 180 days of the date services were rendered.
- A member claim form is available at http://www.BlueOptionSC.com/sites/default/files/user_files/documents/member-claim-form_03.pdf

- Complete the front of each claim form and attach the itemized bills from the provider to it. Before you submit your claims, we suggest you make copies of all claim forms and itemized bills for your records since we cannot return them to you. Completed forms should be mailed to:

  BlueChoice® HealthPlan
  Claims Department
  P.O. Box 6170
  Columbia, SC 29260-6170

C. Grace Periods and Claims Pending Policies During the Grace Period

- This policy has a grace period for premium payments. This means if your premium is not paid on or before the date it is due, it may be paid during the grace period. If the premium has not been paid by 12:01 a.m. of the day following the end of the grace period, the coverage will automatically terminate without further notice. Any claims paid after the last premium-paid date, do not extend this coverage.
- "Pending claims" is the withholding of claims payments to the provider or you during a grace period.
- **Grace Period for Coverage with an Advance Premium Tax Credit (APTC)** – If you paid at least one month's premium and received the APTC, the grace period is three months. During the first month of this grace period, any claims submitted will be processed according to your coverage. Claims will be pended for services provided during the second and third month of the grace period until the full premium due is paid. If premiums are fully paid during the grace period, pending claims will then be paid.
- **Grace Period for Coverage without an Advance Premium Tax Credit** – If you did not receive an APTC, the grace period is 31 days, during which benefit payments will be pended until all premiums are paid.

D. Retroactive Denials

- Claims may be denied retroactively even after services are received.
- To prevent retroactive denials
  1. Pay premiums on time
  2. Do not use your ID card after the policy has terminated
  3. Inform your provider if your policy has terminated

E. Enrollee Recoupment of Overpayments

- Enrollee recoupment of overpayments is the refund of a premium overpayment by you due to over-billing by the issuer, or some other reason you have paid more than is required.
- You may obtain a refund of premium overpayments by contacting Member Services.

F. Medical Necessity and Prior Authorization Timeframes and Enrollee Responsibilities

- Services covered under this policy must be medically necessary and appropriate, and may require prior authorization by BlueChoice®.
- Benefits will be denied for procedures, services or pharmaceuticals when you do not get the required prior authorization. The fact that BlueChoice authorizes services or supplies does not guarantee that all charges will be covered. Benefit determination is made by BlueChoice in accordance with all of the terms, conditions, limitations and exclusions of the policy — including eligibility.
- You should work with your providers to request and obtain prior authorization in advance of receiving services, except for emergency and urgent care services.

G. Drug Exceptions Timeframes and Enrollee Responsibilities

- The Covered Drug List is the list of drugs covered under Blue Option health plans. When necessary, you may request an exception to have a drug covered that is not on this list.
- **Formulary Exception Request (standard or expedited):** If a drug is not covered, you may request a formulary exception by contacting our Pharmacy Benefit Manager (PBM) or by calling the Prior Authorization line at 855-582-2022 to acquire an exception request form. After completing the necessary information, the form can be faxed to 855-245-2134. We must act on a standard request within 72 hours and on an expedited request within 24 hours after we receive your request for a formulary exception. Expedited requests are available only when you have exigent circumstances: a health condition that may seriously jeopardize your life, health or ability to regain maximum function or when you are undergoing a current course of treatment using a non-formulary drug.
- For a standard formulary exception, we will notify you no later than 72 hours following receipt of the request, and if approved, will provide coverage of the approved non-formulary drug for the duration of the prescription, including refills. For an expedited formulary exception, the determination will be made no later than 24 hours following receipt of the request and, if approved, will provide coverage of the non-formulary drug only for the duration of the exigent circumstances.

If your formulary exception request is denied, you can ask for an exception review. The request can be made by you or your prescribing provider. You can ask for an exception review by contacting us to begin the process at:

CVS/Caremark
Appeals Department, MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: 1-866-443-1172

H. Information on Explanation of Benefits

- Individual Explanation of Benefits (EOB)

  Your Explanation of Benefits, or EOB, is a form that gives you details about your claim status. An individual EOB is available for each claim filed.

- Each EOB features important information about health care services you received, how much your health plan covered, how much you may owe your provider and much more. You can find most of the quick details you're looking for in a convenient Summary Information box. The details about your claims are in column format, so you can easily track information about each service you received. You'll also find helpful definitions. You can view your individual EOBs by logging in to My Health Toolkit®.

- Summary EOB

  Please note: Summary EOBs are available for some, but not all, health plan members at this time.

  Summary EOBs offer a convenient way to organize information about your medical bills. Summary EOBs give the status of all of your health insurance claims filed during a certain time period. Each Summary EOB gives information for claims we processed for all individuals under your member ID during the 21-day period. If you had claims filed or processed during that time period, you will receive a Summary EOB. If no claims are filed or processed, you won't receive a Summary EOB for that period.

  The Summary EOB provides all the information you need about your health insurance claims — and it's easy to read and understand. The summary section outlines the costs your health plan covered and the amounts you owe specific providers. It also shows other insurance or Medicare payment amounts, if applicable. You'll also find definitions of some terms and an explanation of your appeal rights. The claims detail section gives more information about each claim, such as charges, allowed amounts and coinsurance. It also explains where you stand on deductible and out-of-pocket amounts.

If you receive Summary EOBs, but would like to view an individual EOB for a particular claim, just log in to My Health Toolkit and click "Health Claims Summary." Then choose the "View EOB" link below the claim.

I. Coordination of Benefits

- A person may be covered for benefits under more than one health plan. In this case, BlueChoice may coordinate benefits with the other plans to prevent duplicate payments and overpayments. Blue Option does not coordinate benefits with other plans except when a member has Medicare coverage.