BusinessADVANTAGE
Transparency in Coverage

A. Out-of-network Liability and Balance Billing

- Benefits are provided both in network and out of network. Using network providers will result in higher benefits. To find a network provider, go to http://www.BlueChoiceSC.com/doctorandhospitalfinder.
- Reduced 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 BlueChoice HealthPlan Advantage 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, minus copay, co-insurance or deductible or for the penalties for not getting authorization. For example, if the provider's billed charge is $100 and the allowed amount 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 provides 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 https://www.BlueChoiceSC.com/sites/default/files/documents/Everybody/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

- A grace period of 31 days will be granted for payment of any premium due (except the first Premium). During the grace period the policy will remain in force, unless the policyholder has given BlueChoice written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. In no event shall the grace period extend beyond the date the policy terminates.
- "Pending claims" is the withholding of claims payments to the provider or you during a grace period.
- Once a grace period begins, after 15 days the 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 get a refund of premium overpayments by contacting the group's benefits coordinator.

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 BusinessADVANTAGE 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 get 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 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, 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 will coordinate benefits with the other plans to prevent duplicate payments and overpayments. This nationally accepted cost-containment program provides that the benefits under this plan plus any benefits due from other group coverage will not exceed the amount of actual expenses charged for services. If a person's other group coverage is responsible for making payments first, BlueChoice cannot pay until information is provided concerning how much the other coverage paid. The person must report to BlueChoice any other group benefit plan for which the person is eligible.