2024 LG Primary Choice Member Guide

BlueChoice® HealthPlan
South Carolina

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

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Welcome to BlueChoice HealthPlan

This is your BlueChoice HealthPlan Member Guide, which outlines some of your benefits and covered services. Please refer to the Benefits Basics section. It contains important topics for you to know. If you need more detailed information, please read the expanded information in the back of the guide.

As your health plan, we're here to help you. If you need more information, assistance or have other questions, please:

Visit our website:
www.BlueChoiceSC.com
and send a secure email
through My Health Toolkit

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

Call Monday – Friday
from 8:30 a.m. – 5 p.m.:
800-868-2528
TTY Services 711 + 800-868-2528

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.

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 more about 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, **www.BlueChoiceSC.com**. From the homepage, you can log in to **My Health Toolkit**®. If you don't have an account, it just takes a few minutes to create one. Be sure to have your member ID card available.

Once you have created a profile, you will have access to your Schedule of Benefits. Select the **My Plan & Benefits** tab at the top of the page. Next select **Health**, then **Health Benefits**.

Certificate of Coverage: This is an in-depth description of covered services, exclusions, limitations and eligibility requirements. You can find your Certificate of Coverage by logging into your **My Health Toolkit** account. Once logged in, select the **My Plan & Benefits** tab at the top of the page. Next select **Health**, then **Health Benefits**. Select the **View Benefit Booklet** link to view the document. You can also request a copy of your Certificate of Coverage from your human resources department.

Our **FOCUS***fwd* **Wellness Incentive Program** is designed to help you lead a healthier lifestyle. By completing health-related activities and challenges, you'll earn up to **$110** in rewards and increase your chances of winning one of the **$1,000 quarterly** and **$5,000 annual** cash rewards in our **Sweepstakes**! Just look for the running man icon (pictured here) indicating a **FOCUS***fwd* initiative and its point values. See page 14 for more information.

One more thing: We know there are a lot of insurance words that may be confusing. Please refer to the glossary on page 38. Thank you for choosing BlueChoice®.

Benefit Basics

IF YOU NEED TO:	THE BASIC ANSWER:	FOR MORE INFORMATION:
Get an overview of your plan	Your plan requires that you use in-network providers (doctors, hospital, etc.) to get benefits. Also, you will need to choose a primary care physician (PCP) for each covered member. PCPs usually specialize in family medicine, internal medicine or pediatrics. We provide coverage only for medically necessary services that we listed as covered in your Schedule of Benefits. You should also check your Certificate of Coverage to see any exclusions or limitations. You can request a copy of your Certificate of Coverage from your human resources department or Member Services. Remember to show your ID card whenever you get medical services.	p. 5
Get information online	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.	p. 7
Learn about benefits for preventive care and how to stay healthy	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 chronic condition programs to help you learn more about chronic conditions, pregnancy and healthy lifestyles.	p. 8
See a doctor	Your plan allows you to choose a PCP in the BlueChoice network. Your PCP will help you manage your care by providing referrals to other providers when needed. Inpatient admissions (except emergency admissions) and certain outpatient services require prior approval. This includes inpatient admissions and certain outpatient services related to mental health and/or substance use.	p. 21
Get urgent care	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. Urgent care coverage includes in-network and out-of-network emergency services for an emergency medical condition. To find a network urgent care center, refer to the Find Care link on our website or contact Member Services. See your Schedule of Benefits to find out what copayment applies. (Hint: Urgent care copayments are much lower than emergency room [ER] copayments.)	p. 22
Be admitted to the hospital	All inpatient care must be authorized in advance, except for emergency admissions. Your PCP 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 Schedule of Benefits to find out more about inpatient deductibles and coinsurance.	p. 22
Get emergency care	If possible, call your PCP. If there's no time to do that, call 911 and/or get to the nearest 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.	p. 23
Get care away from home	With the BlueCard network, you have access to in-network benefits when you are away from home and 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.	p. 25

IF YOU NEED TO:	THE BASIC ANSWER:	FOR MORE INFORMATION:
Fill a prescription	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 you can fill up to a 31-day supply. Your plan covers most drugs, except for lifestyle drugs. Your plan offers a tiered Prescription Drug List, which has six tiers. See your Schedule of Benefits to your cost for each tier and the Prescription Drug List to see which tier applies to your prescription.	p. 26
Get other services	Your plan has coverage for laboratory and X-ray services. You also may have benefits for vision care.	p. 29
Know how much you'll pay	Each plan has its own copayments, deductibles and coinsurance. Your Schedule of Benefits lists what you will pay for varying services. You can also find cost estimators and drug cost comparisons on our website.	p. 30
Learn about claims and other payment issues	You will receive an Explanation of Benefits (EOB) in the mail about once a 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), the required annual certification, and other paperwork issues.	p. 33

Your Plan Overview

All medical care must be coordinated through a primary care doctor in the BlueChoice network. You are responsible for making sure your PCP is in the network before you receive a covered service. You can find this out two ways: You can use the **Find Care** link on our website, or you can contact Member Services. See the Welcome page of this guide for contact information.

What We Pay For

We cover services that are medically necessary and that your plan lists as covered. See your Schedule of Benefits, which can be found when you log in to your My Health Toolkit account, or contact Member Services (see the Welcome page for contact information). We pay for covered services you receive only while you are a member of BlueChoice.

We contract with a network of doctors, hospitals and other health care professionals to provide services to our members. 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.

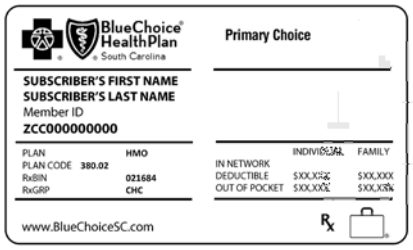
You can find out which PCPs and other providers are in network by using the **Find Care** link on our website or by contacting Member Services (see the Welcome page for contact information).

Remember, BlueChoice must approve in advance all inpatient admissions to the hospital other than emergency admissions. You must notify us of nonemergency inpatient admissions at least two business days before the admission date. If you are uncertain whether 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. You can request a copy of your Certificate of Coverage from your human resources department or Member Services. Services not covered are called exclusions. Services with restrictions are called limitations. You will be responsible for payment of noncovered services. Additional information for this is available in this guide on page 31.

Your ID Card



Whenever you seek medical care, be sure to identify yourself as a BlueChoice member. When you arrive for your appointment, show your BlueChoice member ID card.

Your ID Card Is Digital, Too

Remember, you can access your digital ID card anytime, anywhere from your computer or mobile device.

Advantages of Your Digital ID Card

Your digital ID card is identical to your physical card. It contains your member ID number and other coverage details unique to you. Unlike with your physical card, you don't have to worry about losing it or ordering duplicate copies for your family. You can easily:

- View your card on your smartphone, tablet or computer.
- Email your card to your spouse, children, doctor's office or pharmacy.
- Print your card at home from your smartphone or computer. Use the printed card just like your physical card.

How To Access Your Digital ID Card

To quickly access your digital ID cards, log in to your My Health Toolkit account and select **ID Cards** at the top. To learn more about My Health Toolkit and how to log in or create a new account, see **page 7**.

Don't discard your physical ID card. Some doctors may still want a copy of it for their records. If you have not received a new ID card, the digital card may not be available.

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 schedule, not ours.

My Health Toolkit

You can use My Health Toolkit to see if your plan covers a specific procedure, get more information about your health benefits, check the status of a claim and more. If you don't have an account, it just takes a few minutes to create one. Once you've created your account, be sure to select your contact preferences under **Profile** to tell us how you want to receive our communications.

With My Health Toolkit, you can:

- Find doctors, hospitals, dentists and other health care providers.
- Access Blue365 discount programs (page 10).
- Find prescription information.
- Learn more about eligibility and benefits.
- Get access to My Health Novel, where you can get matched with helpful tools and resources specific to your health needs.
- Learn about and register for the **FOCUS***fwd* Wellness Incentive Program.
- View all of your health plan communications from us through the secure Message Center.
- Get access to health coaching and much more!

when you register for My Health Toolkit

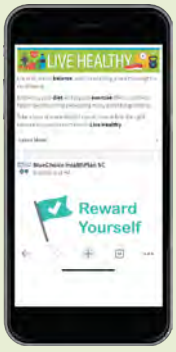
Download My Health Toolkit Mobile App Today

With the mobile app, you can do everything you can on the My Health Toolkit website and more! Download the My Health Toolkit mobile app today to take your insurance benefits with you wherever you go and get access to them whenever you need.

Current My Health Toolkit users can log in to the app with their existing username and password.

New My Health Toolkit users can register through the app. Visit the App Store or Google Play and download today.

*My Health Novel may not be included in select self-funded groups. To confirm, contact Member Services (see the Welcome page for contact information).



Get Our Texts!

Get important information delivered to your smartphone when you sign up for our text messages:

- Keys to using your coverage
- Health and wellness reminders
- Ways you can save

... and more!

To get started, simply call **844-206-0622**. Please have your member ID card ready.

when you sign up to receive text messages

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 **Member Center** section, under the **Resources** section via the **Keys to Using Your Coverage** tab.

All-Inclusive Office Visit Copayment

If your plan offers an office copayment benefit, you have the convenience of an all-inclusive, comprehensive copayment. This means if you visit a network provider, you will pay one copayment for all diagnostic and treatment services in the office.

Services are not limited to routine and sick visits. They include in-office surgical procedures, labs and X-rays with no limits or caps. You can get necessary services at a set cost, with no hidden fees.

Value-Added Benefits and Services

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 per person per contract year for you and your covered family members for individual, couples and family counseling.

Counseling Services:

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

Life Management Services:

Three free life management services per person per contract year are available for you and your covered family members.

- Elder and Adult Care Resources
- Child Care Resources
- College and School Resources
- Financial Counseling and Planning
- Legal Services and Documents
- Parenting/Adoption Resources

Dedicated professionals are available to serve you 24/7. Call **800-968-8143**. Or, for more detailed information about your benefits and helpful articles, assessments, webinars, videos, etc., visit **www.FirstSunEAP.com**.

Blue365 Discounts

for registering for Blue365

You can take advantage of great discount programs and special services with Blue365*, a program offering nationwide discounts. We offer these services and discounts to our members in addition to, but not included in, the services and benefits covered under your policy. Through our value-added services, members have access to special discounts or benefits on services such as the following:

- Discounts on fitness equipment such as a Fitbit and Garmin**, weight loss programs, fitness centers, and other health & wellness supplies
- Discounts on footwear from multiple brands
- Discounts on hearing and vision equipment such as glasses, sunglasses, hearing aids, and even Lasik eye surgery
- Discounts on pet supplies and insurance
- Discounts on travel for theme park getaways, hotels, and rental cars to get there

*The Blue365 program is brought to you by the Blue Cross Blue Shield Association. The Blue Cross Blue Shield Association is an association of independent, locally operated Blue Cross and/or Blue Shield companies

**These are independent companies that offer discounts to BlueChoice HealthPlan members.

Health Management 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! We welcome your participation and hope you'll take advantage of these great programs. Best of all, they're included as part of your health insurance benefits.

Prevention and wellness programs:

- Back Care
- Healthy and Active Kids and Teens
- Maternity
- Tobacco Cessation

Behavioral health programs:

- Anxiety Management
- Adult Attention-Deficit Hyperactivity Disorder (ADHD)
- Bipolar Support
- Depression
- Moms Support Program
- Recovery Support

Condition support programs:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Kidney Disease
- Diabetes
- Heart Disease
- Heart Failure
- High Blood Pressure
- High Cholesterol
- Metabolic Health
- Migraine

for completing your first call in select Great Expectations programs

*Participation in these programs earn entries into the **FOCUS***fwd* Wellness Incentive Program.

For more information or to enroll in a Great Expectations program, you can call us at **855-838-5897** or visit **www.BlueChoiceSC.com/GreatExpectations**.

*These programs are eligible for **FOCUS***fwd* entries. See page 14 or log in to My Health Toolkit to learn more.

My Health Novel

My Health Novel matches you with helpful resources and tools based on your specific health needs. With it, you can access weight management, behavioral health, women's health and musculoskeletal health mobile apps at no cost.

To see if you qualify, log in to your My Health Toolkit account and select **My Health Novel**. Then, take the quick, one-minute assessment. After taking the brief health quiz, you'll be matched to the program that is best for you.

for completing the assessment in My Health Novel

Great Expectations *for Weight Management*

There are countless weight loss programs that try to guarantee results for everyone in a short amount of time. In reality it's the slow, gradual changes that last a lifetime.

Our **Great Expectations** *for Weight Management*, program uses proven strategies to help you make lasting changes that are personalized for you. With the help of **My Health Novel**, you'll be matched with helpful tools and resources based on your specific health needs.

Some of the programs included are WW (Weight Watchers® reimagined), Virgin Pulse* and more. Depending on the program, you may be provided with tools to help you succeed, like a free Fitbit activity tracker** or wireless scale.

* Fitbit, Weight Watchers and Virgin Pulse are independent companies that offer health and wellness programs, products and services to members of your health plan.
** For members who complete program participation requirements. Requirements vary; check with your program for details. Applies to certain Fitbit models. Limited to one per person. Solera Health reserves the right to substitute an alternate activity tracker. Solera Health is an independent company that offers a health management program on behalf of BlueChoice.

Behavioral Health Resources

If you are living with a mental health condition, you may be struggling to cope with life's challenges effectively. You are not alone. One in 5 adults will need mental health treatment in his or her lifetime. The good news is that help is available.

CBA offers case management to help guide members through the treatment process. CBA is a separate company that manages behavioral health benefits on behalf of BlueChoice. Case management is a free, voluntary program. When you join the program, you will partner with a case manager. Your case manager will help you get the most out of your behavioral health, medical and pharmacy benefits.

Case managers can help with a variety of conditions, including:

- Alcohol or drug use.
- Bipolar disorder.
- Borderline personality disorder.
- Depression.
- Eating disorders.

Your case manager will serve as your personal advocate, working with you to help you reach your goals.

For more information, call CBA at **800-868-1032**.

Also, Blue CareOnDemand offers video chat with a licensed counselor, therapist, psychologist or psychiatrist from your home or wherever you feel most comfortable. Support doesn't have to stop after your first consultation. You can schedule follow-up appointments at the time and frequency that are right for you.

Access Blue CareOnDemand at **www.BlueCareOnDemandSC.com** or download the Blue CareOnDemand app on your Apple or Android device. Cost of Blue CareOnDemand visits varies by visit type and provider selected, and it is subject to plan benefits. To see other programs available, visit our **Health Management Programs page**.

My Diabetes Discount Program

Get support from a program that helps pay for your insulin. My Diabetes Discount Program, a program offered by BlueChoice, can help. Over several months, you'll complete actions on a checklist. Then you'll be able to receive your insulin with a **$0 copayment**. Take a look at the checklist below, and you'll see there are things you might be doing already … or know you should be.

Program Checklist

To begin receiving your $0 copayment, please complete the following requirements:

- ☐ Visit your primary care physician for a checkup that includes:
  - ☐ A comprehensive metabolic panel lab test[1] OR a basic metabolic panel.
  - ☐ An A1C test.
  - ☐ A diabetes risk factor assessment of your feet and eyes.
- ☐ Get a flu vaccine.
- ☐ Complete diabetes education.[2] You can meet this requirement by completing ONE of the following:
  - ☐ Complete the Diabetes module in My Health Planner℠.
  - ☐ Complete one call with your care manager OR view one diabetes education article/video.
  - ☐ Complete one digital conversation with a care manager using My Health Planner. Conversations must include at least three interactions in one day.
  - ☐ Complete an approved diabetes education session at an approved independent facility.

You must maintain these requirements, including two semiannual A1C tests, on an annual basis to continually receive discounted benefits.[3]

You will continue receiving your $0 copayment by completing the following annually:

- ☐ Visit your primary care physician for a checkup that includes:
  - ☐ A comprehensive metabolic panel lab test[1] or a basic metabolic panel.
  - ☐ A diabetes risk factor assessment of your feet and eyes.
- ☐ Complete two A1C tests (one every six months).
- ☐ Get a flu vaccine.
- ☐ Complete diabetes education.[2] You can meet this requirement by completing ONE of the following:
  - ☐ Complete the Diabetes module in My Health Planner. If you have already completed the Diabetes module, you may complete the High Blood Pressure, High Cholesterol or Weight Management module.
  - ☐ Complete one call with your care manager or view one online education material **per quarter for four consecutive quarters.**
  - ☐ Complete one digital conversation with a care manager using My Health Planner **per quarter for four consecutive quarters**. Conversations must include at least three interactions in one day.
  - ☐ Complete an approved diabetes education session at an approved independent facility.

[1]Members under the age of 18 require a fasting glucose test instead of a comprehensive metabolic panel test.
[2]For members under the age of 18, the parent/guardian must meet the diabetes education requirement.
[3]The $0 insulin copayment will be available for one year from the start date of the benefit — for example, April 1, 2024, through March 31, 2025.
My Diabetes Discount program may not be included in select self-funded groups. To confirm, contact Member Services (see the Welcome page for contact information).

You know how serious diabetes can be when it's not well controlled. Please check out this free program and get more details by calling the Member Services number on the back of your member ID card.

FOCUS*fwd* Wellness Incentive Program

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

$70

FOCUS Points*

Get a **$70 reward** and **40 Sweepstakes entries** when you complete the following activities that are important to improving your overall health: Personal Health Assessment, annual wellness exam, and preventive screening or flu vaccine.

$40

GET FIT*

The GET FIT quarterly challenge lets you earn rewards with each step you take. Now with a new challenge every three-months, it's never been easier to get started.

You'll receive **$10 in rewards** and **10 Sweepstakes entries** for each challenge you complete, for a total of **$40 in rewards** and **40 Sweepstakes entries** each calendar year.

$5K

Sweepstakes

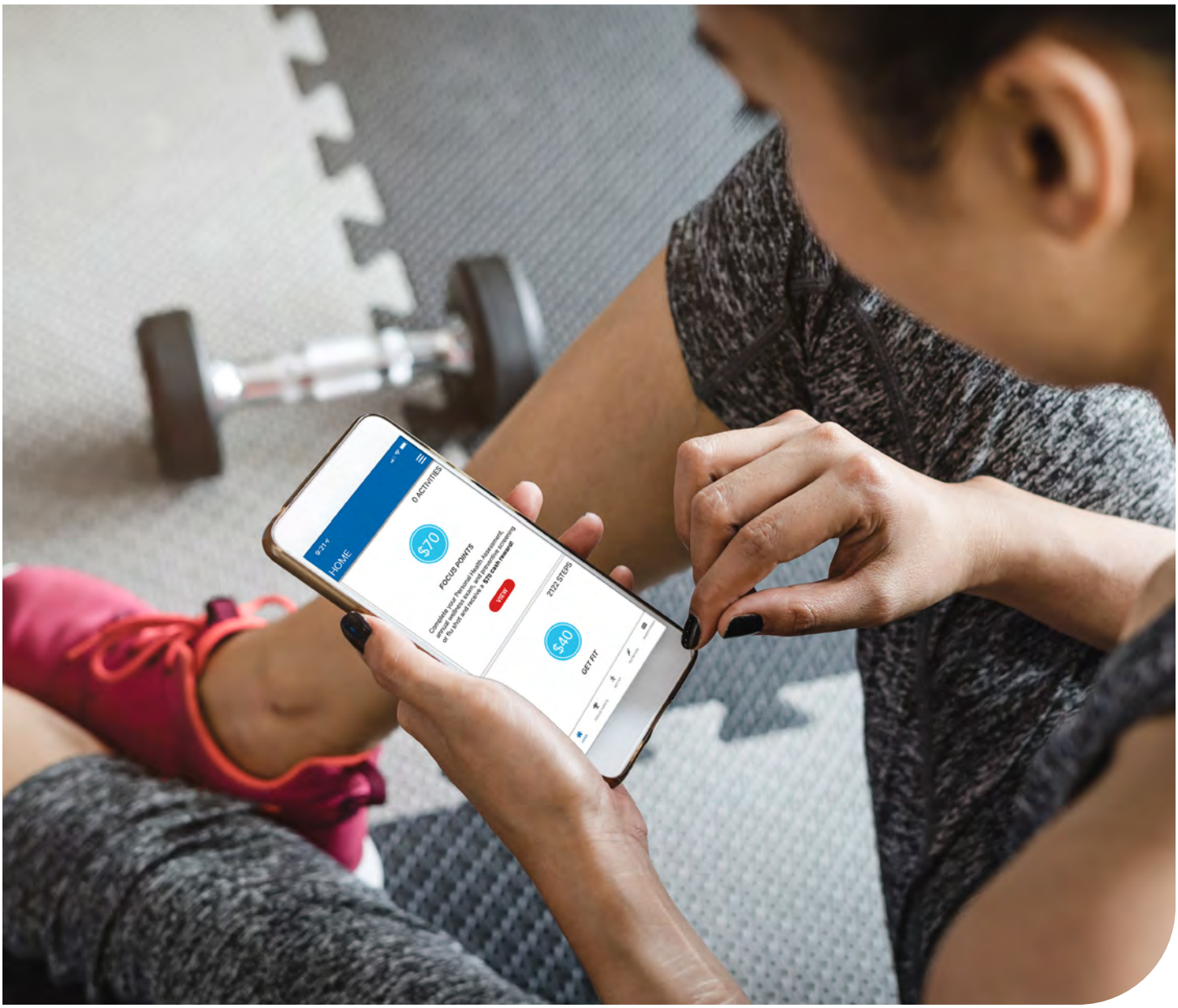
You earn **Sweepstakes** entries for every activity you complete in **FOCUS***fwd*, increasing your chances to win one of the **$1,000 quarterly** and **$5,000 annual cash rewards**. You even earn **10 Sweepstakes entries** by simply signing up for **FOCUS***fwd*!

*These are calendar-year programs and will restart annually.

Get started:

1. Visit **www.BlueChoiceSC.com**.
2. Log in to **My Health Toolkit**.
3. Select the **FOCUS***fwd* **Wellness Incentive Program** link to get registered.
4. Be sure to enter your email address to be eligible to win one of the Sweepstakes rewards!

FOCUS*fwd* is available to applicable subscribers and their spouses (aged 18 and older). You can call the Customer Service number located on the back of your member ID card to confirm if this program is available to you.



Stay Connected to Your Health and Your Rewards With the **FOCUS***fwd* App.

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

- Complete activities in **FOCUS Points** that are important to your overall health.
- Register and participate in the quarterly **GET FIT** step challenges.
- Connect your activity tracker to start participating in **GET FIT** and sync your steps at least once every 30 days.
- Complete activities that help you stay connected to BlueChoice and improve your health, all while earning entries into the **FOCUS***fwd* **Sweepstakes**.
- Redeem your **FOCUS***fwd* rewards.

Download the FOCUS*fwd* App and Link Your Account:

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

Download on the App Store

ANDROID APP ON Google play

Get Moving With GET FIT

The **GET FIT** challenge rewards you for taking steps toward your exercise goals — an average of 5,500 steps per day to be exact. There's a new challenge cycle every three months. You'll receive **$10 in rewards** and **10 Sweepstakes entries** for each challenge you complete, for a total of **$40 in rewards** and **40 Sweepstakes entries** each calendar year.

GET FIT Step Challenge

CHALLENGE 1	CHALLENGE 2	CHALLENGE 3	CHALLENGE 4
500,000 STEPS	500,000 STEPS	500,000 STEPS	500,000 STEPS
January 1 – March 31	April 1 – June 30	July 1 – September 30	October 1 – December 31

Get started:

1. Visit **www.BlueChoiceSC.com**.
2. Log in to **My Health Toolkit**.
3. Select the **FOCUS***fwd* **Wellness Incentive Program** link to get registered.
4. Select **GET FIT**.
5. Select **I Want to GET FIT!**

Track Your Physical Activity

Earn **Sweepstakes** entries for tracking your physical activity using your smartphone or activity tracker.* **This allows you to participate in GET FIT**. Once your device is connected, your physical activity is automatically tracked. If you choose not to participate in **GET FIT**, you can still earn **Sweepstakes** entries by recording your physical activity. Simply connect your smartphone or activity tracker and walk 5,000 steps three days a week, or manually record your physical activity in **FOCUS***fwd* three days per week. Either way, you'll earn one **Sweepstakes** entry each week.

To get connected:

1. Visit **www.BlueChoiceSC.com**.
2. Log in to **My Health Toolkit**.
3. Select the **FOCUS*fwd* Wellness Incentive Program** link.
4. Select **GET FIT**.
5. Select the **Connect** button on the compatible device (Fitbit or Garmin**). Apple Health and Google Fit users must connect using the **FOCUS*fwd*** app.
6. You will be automatically taken to your device account. Select **Allow** to provide **FOCUS*fwd*** access to your device.
7. Once completed, the **Connect My Device** screen will display as connected.

To get connected using the FOCUS*fwd* app:

1. Visit **www.BlueChoiceSC.com** on your mobile device.
2. Log in to **My Health Toolkit**.
3. Select the **FOCUS*fwd* Wellness Incentive Program** link.
4. Select the **Learn more** button.
5. Select the **Link FOCUS*fwd* Account** button.
6. You will automatically be directed to the App Store or Google Play.
7. Download the **FOCUS*fwd*** app.
8. Open the app and follow the prompts to connect your device.

Once you link your **FOCUS*fwd*** account in the app, you can access **FOCUS*fwd*** directly from the app without going through My Health Toolkit. To learn more about device integration, go to **www.BlueChoiceSC.com/DeviceIntegration** or scan the QR code to the left.

*If you need to manually record your physical activity, select **Record Here** in the **Record Your Physical Activity** tile in **Sweepstakes**. However, you will not be able to participate in GET FIT without an integrated device.

**Fitbit and Garmin are independent companies that provide health and wellness products and services to members of BlueChoice HealthPlan.

FOCUS*fwd* is available to applicable subscribers and their spouses (aged 18 and older). You can call the Customer Service number located on the back of your member ID card to confirm if this program is available to you.

Personal Health Assessment

Taking the Personal Health Assessment (PHA) is just one of the many ways you can take steps toward better health. Unfortunately, many chronic health conditions show no warning signs. Your PHA may provide insights on your risk for developing certain chronic conditions so you can take preventive action and stay focused on the things that matter most to you.

Your Privacy Is Our Priority

Protecting your personal health information is very important to us. All the answers you give are confidential and protected by the federal HIPAA laws.

You Matter

Choices you make every day can impact your health. The PHA can help you identify personal risk factors related to:

- Nutrition.
- Tobacco use.
- Physical activity.
- Current health.
- Health history.
- Alcohol use.
- Biometrics.
- Stress and depression.

Instant Feedback

After you've completed the assessment, you'll receive:

- 15 entries into the **FOCUS***fwd* Wellness Incentive Program Sweepstakes.
- Personalized experiences based on responses to survey questions.
- Tips and resources for lowering risk factors.

for completing your Personal Health Assessment

Easy Access to Your PHA

You can complete your assessment through My Health Toolkit. Log in to your **My Health Toolkit** account from the app or by visiting **www.BlueChoiceSC.com** to learn more about the **FOCUS***fwd* Wellness Incentive Program and how to complete your PHA.

The assessment takes less than 15 minutes to finish and can be completed in the privacy of your home or office. If you don't have a profile, you must first register for My Health Toolkit. After you complete your PHA, you'll be one step closer to completing our FOCUS Points* program. With FOCUS Points, you get a **$70 cash reward and 40 entries** into the Sweepstakes when you complete the following activities that are important to improving your overall health: Personal Health Assessment, annual wellness exam, and preventive screening or flu vaccine.

*This is a calendar-year program and will restart annually.

Doctor Visits Anytime, Anywhere

With Blue CareOnDemand Powered by MDLIVE, you can visit with a doctor via smartphone, tablet or computer rather than visiting an office or urgent care facility.

BLUE CareOnDemand℠

Powered by MDLIVE

Services Available With Blue CareOnDemand

Virtual Primary Care: Get convenient wellness screenings, routine care, and help with chronic condition management.

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

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

Dermatology: Skip the long waits at a specialist's office. Get help with conditions such as acne, rosacea and eczema with MDLIVE's dermatology services.

Get Started Now!

You can access Blue CareOnDemand through your **My Health Toolkit** account:

1. Log in to your **My Health Toolkit** account by visiting **www.BlueChoiceSC.com** or using the My Health Toolkit app.
2. Select **Blue CareOnDemand** to link your account and to start using the services.

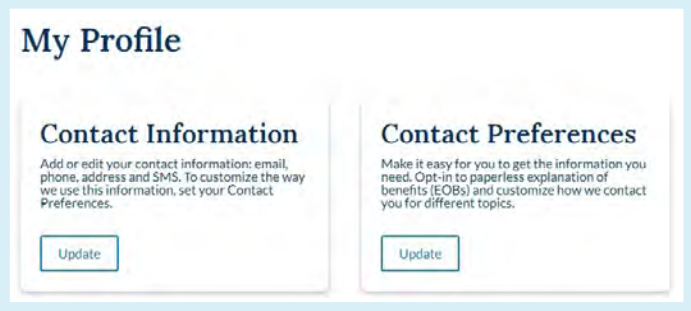
for Blue CareOnDemand registration

Note: Starting in 2024, you will need to create a new profile when accessing Blue CareOnDemand through My Health Toolkit. Any existing Blue CareOnDemand accounts or apps can safely be deleted anytime.

HELP WANTED

BlueChoice HealthPlan needs **your** help!

Everyone gets alerts about unimportant news, so why not get news about the most important topics of all: YOU and YOUR HEALTH!



Get connected today:

1. Go to **www.BlueChoiceSC.com**.
2. Sign in to **My Health Toolkit**.
3. Select **Profile.**
4. Then select **My Account**.

Add your contact information under **Contact Information** and set your contact preferences under **Contact Preferences**.

Setting your contact preferences tells us how you want to receive our communications.

Once connected, you'll receive all this:

- Keys to using your coverage
- Health and wellness reminders
- Updates on program enhancements
- Ways you can save

… and more!

If You Need To See a Doctor

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 PCP. Typically, PCPs 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 PCP 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.

All PCPs in our network are required to have 24-hour telephone service or another physician on call if they are unavailable. You have the security of knowing a medical professional is ready to help you 24/7. Once you decide on a doctor 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.

Visit **www.BlueChoiceSC.com/FindCare** to find a provider in our Choice Level Funded network. 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 Welcome page). We will give you directory information by telephone or in print upon request.

See your Schedule of Benefits to find out the cost of your services when you see your doctor.

Routine Care

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

Gynecologist (GYN)

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

If 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 by a PCP. If you receive care from one of our Choice Level Funded network specialists, you will have Choice Level Funded network benefits for services your plan covers.

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 and Plan of Benefits for a list of covered services. If you need one of these services (other than inpatient admissions), your plan allows you to self-refer to the Choice Level Funded network provider of your choice.

If You Need Urgent Care

A condition is considered urgent if it is not life-threatening but still needs immediate attention to protect your health. Examples of urgent care conditions include the following:

- 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 **Find Care** link on our website at **www.BlueChoiceSC.com** or contact Member Services. See the Welcome 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. Urgent care coverage includes in-network and out-of-network emergency services for an emergency medical condition. 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 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 **Find Care** link on our website at **www.BlueChoiceSC.com.** You can also contact Member Services (see the Welcome page for contact information) and 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, whether or not the service is received in network or out of network.

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. These can both be found when you log in to your My Health Toolkit account.

Examples of situations that are not considered an emergency include the following:

- 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 these:

- 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.

When Is an Emergency Not an Emergency?

You or a loved one is in pain. How do you know how sick you are? Should you rush to the hospital emergency room? That could cost you $250 or more. Should you wait to see your primary care doctor? The chart below should help you decide what's best for your ailment and your pocketbook.

TYPE OF VISIT	EXAMPLE OF OUT-OF-POCKET COST*
Primary Care Doctor	$30 per visit
Urgent Care	$60 per visit
Emergency Room	$3,500 deductible, then 40% coinsurance
*Benefits vary. Please consult your Schedule of Benefits.	

HEALTH ISSUE	PRIMARY CARE DOCTOR Out-of-Pocket Cost: $	URGENT CARE Out-of-Pocket Cost: $$	EMERGENCY ROOM Out-of-Pocket Cost: $$$$
Mild asthma	✓	✓	✗
Sprain, strain or back pain	✓	✓	✗
Needs immediate attention but is not life-threatening	✓	✓	✗
Cuts or wounds, controlled bleeding	✓	✓	✗
Signs of a heart attack, such as chest pains	✗	✓	✓
Routine physical, vaccinations	✓	✗	✗
Head or eye injuries	✗	✗	✓
Uncontrolled bleeding	✗	✗	✓
Signs of stroke: numbness of face, arm and/or leg on one side of the body	✗	✗	✓
Life-threatening injury or symptom	✗	✗	✓

You can also use Blue CareOnDemand to visit with a doctor wherever you are via smartphone, tablet or computer. Each Blue CareOnDemand visit costs the same amount as an office visit with your primary care doctor. For more information, check out page 19.

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. If you have an emergency, please go to the nearest health care facility.

In the United States:

- Always carry your current member ID card.
- Call us for precertification or prior authorization if necessary. Refer to the phone number on the back of your member ID card.
- When you arrive at the participating doctor's office or hospital, show the provider your ID card.

After you receive care, you should:

- Not have to complete any claim forms.
- Not have to pay upfront for medical services, except for the out-of-pocket expenses (noncovered services, deductible, copayment and coinsurance) you normally pay.
- Receive an Explanation of Benefits from BlueChoice.

Around the world:

- Always carry your current member ID card.
- Before you travel, contact Member Services at the phone number listed on the back of your member ID card for coverage details. Coverage outside the U.S. may be different.
- If you need medical assistance, call the Service Center for Blue Cross Blue Shield Global® Core at **800-810-BLUE** (2583) or call collect at **804-673-1177**, 24/7. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization if necessary.

Inpatient claim: Call the Blue Cross Blue Shield Global Core Service Center if you need inpatient care. In most cases, you should not need to pay upfront for inpatient care except for the out-of-pocket expenses (noncovered services, deductible, copayment and coinsurance) you normally pay. The hospital should submit the claim on your behalf.

In addition to contacting the Service Center, call us for precertification or preauthorization. Refer to the phone number on the back of your member ID card. ***Note:*** *This number is different from the Service Center phone numbers listed above.*

Professional claim: You may need to pay upfront for care received from a doctor and/or hospital. Complete a Blue Cross Blue Shield Global Core International claim form and send it with the bill(s) to the Service Center (the address is on the form). You can also submit your claim online. The claim form is available online at **www..BCBSGlobalCore.com**.

In an emergency, go directly to the nearest hospital.

If You Need a Prescription Drug

Your plan includes prescription drug coverage. You can find a complete Prescription Drug List and a list of network pharmacies in South Carolina quickly on our website under **Member Center**. Certain prescription drug coverage services are administered by Optum Rx®, an independent company that provides pharmacy benefit management on behalf of BlueChoice.

What Is the Prescription Drug List?

The Prescription Drug List 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 Prescription Drug List 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 Prescription Drug List

The drug list has six coverage levels, called tiers. Please check your Schedule of Benefits to find out how much you will pay for a drug on each of the tiers and the Prescription Drug List to see which tier your prescription is in. The six-tier pharmacy copayment benefit is in place to better allow management of the always changing prices of drugs in the marketplace.

MEMBER COST	DRUG TIER	USUALLY INCLUDES
$	Tier 1	Lowest-cost prescription generic and some over-the-counter drugs.
$$	Tier 2	Prescription generic and some over-the-counter drugs.
$$$	Tier 3	Brand-name drugs that don't have a generic available. Also may include higher-priced generics that have more cost-effective options at lower tiers.
$$$$	Tier 4	Brand-name drugs that have brand-name or generic options at lower tiers. Also may include higher-priced generics that have more cost-effective options at lower tiers.
$$$$$	Tier 5	Specialty drugs that are more cost-effective than other specialty drugs that treat the same conditions. Also may include some nonspecialty brand-name or generic drugs that have more cost-effective options at lower tiers.
$$$$$$	Tier 6	Specialty drugs that have more cost-effective alternatives at Tier 5. Also may include some nonspecialty brand-name or generic drugs that have more cost-effective options at lower tiers.

As drug prices change and new generic medicines come into the market, you may see a change in the copayment for the brand-name drugs that now have a generic. As the new generics become more available in the market, you may also see the copayment for the generic drug decrease to align with the decreasing cost of the drug. These changing copayments are in place to better manage the pharmacy benefit and make the overall cost of your health insurance more affordable.

Please note that if a plan has a brand-name deductible, any Tier 3 or Tier 4 medication will process to that deductible before applying benefits.

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

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 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 the necessary medical information. We will notify you of our decision by mail.

Prescriptions Requiring Prior Authorization

Some medications your doctor prescribes may require prior approval from us before your plan will cover them. To get prior approval, your physician must contact our pharmacy benefit manager at **855-811-2218**. A drug must meet the U.S. Food and Drug Administration (FDA) prescribing guidelines 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 — we will deny prior authorization, except as required by South Carolina law in treatment of cancer. If your doctor would like 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 the necessary medical information. We will notify you of our decision by mail.

Specialty Drugs

Specialty prescription drugs treat complex or chronic medical conditions. They are often oral or self-injected and usually require patient-specific dosing and careful clinical monitoring. Your plan requires you to have specialty drug prescriptions filled through a specialty pharmacy. If you have a prescription for one of these medications, please call **877-259-9428**. Specialty drugs are available for a 30-day supply. 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.

You may use a prescription drug coupon or discount card unless a generic drug is available. If you do not use the generic drug **when available**, your costs may not be covered. **If a drug manufacturer provides any form of direct support (cash, reimbursement, coupon, voucher, debit card, etc.) for some or all of the cost sharing on the purchase of prescription and/or specialty drugs, this amount will not be counted toward the member's annual limitation on cost sharing. The drug will still be considered a covered prescription drug.**

To see the drugs listed on the Specialty Drug List, go to our website at **www.BlueChoiceSC.com**, select **Member Center**, then your network, then Pharmacy Benefits, or you can contact Member Services (see the Welcome 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 Welcome 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 Prescription Drug List 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 Prescription Drug List?

If your drug is not on this drug list, call Member Services to make sure your drug is not covered. If you learn we do not cover your drug, you have two choices:

1. 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 Prescription Drug List. Similar drugs that are preferred may be easier to get and cost you less than nonpreferred drugs.
2. Ask BlueChoice to make an exception and cover your drug. We will require additional medical documentation from your physician. Call **855-811-2218**.

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 services 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 Welcome page for contact information).

Blue Dental

Proper dental care can help you spot issues early, like diabetes, heart disease, osteoporosis, oral cancer and kidney disease. Comprehensive dental coverage may be included in your plan. To confirm coverage, contact Member Services (see the Welcome page for contact information).

When You Need To Know What You Will Pay

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 these payment categories may not apply to you:

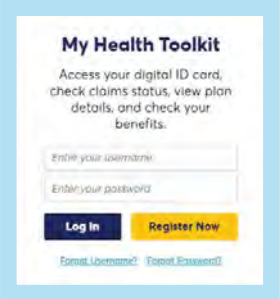
- **Copayment:** The fixed dollar amount you pay for a particular medical service. For example, if your health plan has a $20 copayment for an office visit, you would be responsible for paying $20 every time you visit the doctor.
- **Coinsurance:** The percentage of covered expenses that you must pay. 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 an out-of-network provider, you will be responsible for all charges above the allowed 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 noncovered 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 page 7 of this guide for more details about My Health Toolkit.



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

What We Do Not Pay For

Please refer to your Certificate of Coverage for a complete list of the services your plan doesn't cover. You can request a copy of your Certificate of Coverage from your human resources department or Member Services. Services we don't cover are called exclusions. Services with restrictions are called limitations. You will be responsible for payment of noncovered 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.
- Illness contracted or injury sustained as the result of war or act of war (whether declared or undeclared), participation in a riot or insurrection, or 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.

- Services and supplies related to cosmetic surgery, as determined by us, unless otherwise required to be covered by this Certificate, the Schedule of Benefits or applicable law. This means any plastic or reconstructive surgery done mainly to improve the appearance of any body part and from which no improvement in physiologic function is reasonably expected, unless performed either to correct functional disorder or as a result of an injury.
  Excluded cosmetic surgery includes but is not limited to:
  – Surgery for sagging or extra skin.
  – Any augmentation, reduction, reshaping or injection procedures.
  – Rhinoplasty, abdominoplasty, liposuction and other associated surgery
  – Any procedures using an implant that doesn't alter physiologic function or isn't incidental to a surgical procedure.
  Any services a Member receives due to complications of cosmetic surgery are not covered.
- Radial keratotomy, myopic keratomileusis, Lasik surgery, INTACS surgery and any surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error. This exclusion does not include the treatment and management of keratoconus unresponsive to contact lens therapy.
- 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 nonsurgical treatment of the feet, except non-FDA approved technologies for nonsurgical foot treatment related to diabetes.
- For dental work or treatment which includes hospital or professional care in connection with:
  – An operation or treatment for the fitting or wearing of dentures, regardless if needed due to injury of natural teeth due to an accident.
  – Orthodontic care or treatment of malocclusion.
  – Operations on or treatment of or to the teeth or supporting bones and/or tissues of the teeth except for removal of malignant tumors or cysts.
  – Any treatment of an injury to natural teeth due to an accident not received within six months of the accident date; injuries incurred while the member is in the act of chewing or biting is not covered.
  – Removal of teeth, whether impacted or not.
  – Any operation, service, prosthesis, supply or treatment for the preparation for and the insertion or removal of a dental implant.
  This exclusion does not apply to cleft lip and palate services or facility and anesthesia services that are medically necessary because of a specific organic medical condition including but not limited to congestive heart failure, asthma or chronic obstructive pulmonary disease that requires hospital-level monitoring.
- 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.
- Services, procedures, charges, supplies, equipment or pharmaceuticals for which authorization is required and not obtained.
- 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 your policy.
- Hearing aids or examinations for the prescription or fitting of hearing aids.

For a complete list of exclusion and limitations, please review the Certificate of Coverage for your health plan. You can request a copy of your Certificate of Coverage from your human resources department or Member Services.

Claims, Coverage and Payment Concerns

Explanation of Benefits (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 network provider will file your claims for you.

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.

Coordination of Benefits (COB)

We work hard to control the rising costs of health care. One way we do this is through Coordination of Benefits (COB). COB helps us ensure you receive all 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.

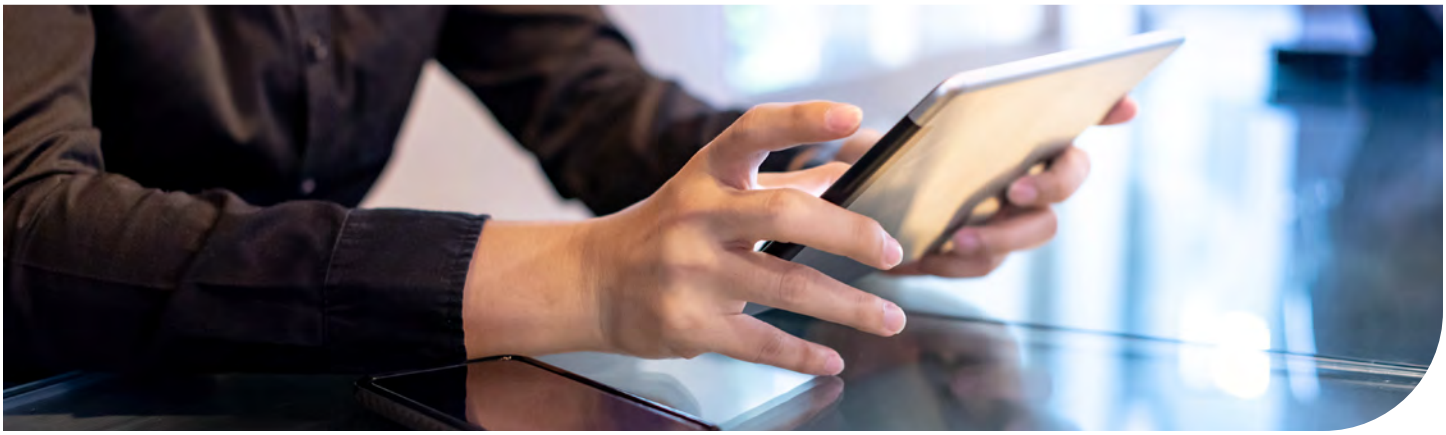
Since an individual's health care coverage can change frequently, we will send you a questionnaire once a year asking if you have other health care coverage. We will use the information you provide to determine which plan should pay first. Please take a moment to complete the questionnaire and return 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-sustaining employment because of a behavioral health illness or physical handicap and 2) mainly dependent upon the employee or the employee's spouse for support and maintenance. The handicap must have developed the before the dependent reached age 26. 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.



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 180 of receiving the denial. You can appeal a decision by calling Member Services (see the Welcome page for contact information) or by faxing your appeal to **803-714-6443**. Your appeal must include the following:

- 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" under health care reform law. Please call our Member Services department (see the Welcome 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 can request an external review without completing the appeal process if one of these takes place:

1. Your physician has certified in writing that you have a serious medical condition.
2. The denial of coverage was based on our determination that the service is investigational or experimental and your physician certifies you have a serious disability, or you have a life-threatening disease or medical and scientific evidence shows that treatment that was denied is more beneficial to you than available standard health services or treatments. 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 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.

Authorization To Disclose Protected Health Information

We will not discuss anything about you with anyone else without your permission. If you would like for us to be able to speak with someone else, please complete the Authorization To Disclose Protected Health Information to a Third Party found on page 40 and send it to the address on the form. Having this form on file will allow us to discuss your coverage with the person you list, without you having to give permission each time you want that person to contact us on your behalf.

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.

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.

Rights and Responsibilities

As a member, you have certain rights. You also have some responsibilities. As part of our ongoing efforts to keep you informed, we've listed your rights and responsibilities here.

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 PCP from our network.
3. Members have the right to expect their PCP 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 teamwork.
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.

Glossary

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. This percentage applies to the negotiated rate or lesser charge when we have negotiated rates with that provider.

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 Welcome 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.

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

Participating Providers — Also referred to as network (or in-network) 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, routine checkups, and sick care or treatment of chronic illnesses.

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

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO A THIRD PARTY

1. **Member Information.** The member is the person whose information may be disclosed.

   Name: _____ Date of Birth: _____ Telephone Number: _____

   Mailing Address: _____

   Member ID Number: _____

2. **Authorization.** I authorize BlueChoice HealthPlan of South Carolina Inc. to disclose the above-listed member's protected health information to the following person/entity in the manner described in Section 3.

   Name: _____

   Mailing Address: _____

   Telephone Number: _____ Relationship: _____

3. **Scope of Authority.** I authorize the disclosure of my protected health information to the above-named person/entity as follows:

   ☐ BlueChoice® may disclose **any** of my protected health information (except psychotherapy notes) that the above-named person/entity may request. If applicable, this information may include information pertaining to chronic diseases; behavioral health conditions; communicable diseases, including HIV or AIDS; and/or genetic information. **Please initial here _____ to also include any alcohol and substance use records. OR**

   ☐ BlueChoice may disclose **ONLY** the following protected health information to the above-named person/entity:

   _____

   _____

4. **Purpose.** This authorization is made (check only one):

   ☐ At my request. **OR**

   ☐ For the following purpose(s) (i.e., civil litigation, Worker's Compensation, etc.):

   _____.

5. **Expiration and Revocation.**

   Expiration: This authorization will expire on _____/_____/_____.
   If no date is indicated above, expiration will be 12 months after termination of my coverage with my health plan.

   Revocation: I understand that I may revoke this authorization at any time by sending written notice of my revocation to the address shown below.

   Please note: I understand that revocation of this authorization will not affect any action taken by BlueChoice in reliance on this authorization before my written notice of revocation was received.

6. **Signature.** Any individual age 16 or over who wishes to grant authorization must complete his or her own authorization form. I am making this authorization voluntarily and have had full opportunity to read and consider the contents of this authorization. I understand that BlueChoice will not condition my enrollment in a health plan, eligibility for benefits or payment of claims upon my signing this authorization. I further understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

   Signature: _____ Date: _____

   Personal Representative's Signature: _____ Date: _____

   If this authorization is completed by a representative on behalf of the person, the representative must **attach legal documentation** establishing authority to act as the person's representative.

PLEASE RETURN THIS FORM TO: BlueChoice HealthPlan of South Carolina Inc., Attn: Privacy Official (AX-400), PO Box 6170, Columbia, SC 29260-6170. Fax number: 803-264-0253

BlueChoice® HealthPlan
South Carolina

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.

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- 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.

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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

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.

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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.

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: Privacy Officer
I 20 East @ Alpine Road (AC-200) Columbia, SC 29219

803-264-7258 (telephone)
803-264-7257 (fax)

Summary of the South Carolina Life and Accident and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

Residents of South Carolina who hold life insurance, annuities, or health insurance policies should know that the insurance companies and health maintenance organizations (HMOs) licensed in this state to write these types of insurance are required by law to be members of the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA). The purpose of SCLAHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, SCLAHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through SCLAHIGA is limited. Consumers should shop around for insurance coverage and exercise care and diligence when selecting insurance coverage.

Disclaimer

Under South Carolina law, the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA) may provide coverage of certain direct life insurance policies, accident and health insurance policies, annuity contracts and contracts supplemental to life, accident and health insurance policies and annuity contract claims (covered claims) if the insurer becomes impaired or insolvent. South Carolina law does not require the SCLAHIGA to provide coverage for every policy. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.**

Coverage is generally conditioned upon residence in this state. Other conditions that may preclude or exclude coverage are described in this notice. Even if coverage is provided, there are significant limits and exclusions. Please read the entire notice for further details on limitations and exclusions.

Insurance companies and insurance agents are prohibited by law from using the existence of the SCLAHIGA or its coverage to sell you an insurance policy. You should not rely on the availability of coverage under SCLAHIGA when selecting an insurer. The South Carolina Life and Accident and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

If you think the law has been violated, you may file a written complaint with the SCLAHIGA or the South Carolina Department of Insurance at the addresses listed below

South Carolina Life and Accident and Health Insurance Guaranty Association Attention: Executive Director P.O. Box 8625 Columbia, SC 29202	**South Carolina Department of Insurance** Attention: Office of Consumer Services 1201 Main Street, Suite 1000 Columbia, SC 29201 Electronic complaint submission via www.doi.sc.gov/complaint

Please attach copies of all pertinent documentation. You may submit a written complaint or a complaint electronically to the Department through submission of the electronic form on the Department's website at www.doi.sc.gov/complaint. You should receive a response to your complaint within 10 days.

This safety-net coverage is provided for in the South Carolina Life and Accident and Health Insurance Guaranty Association Act (the Act). The following summary of the Act's coverages, exclusions and limits does not cover all provisions of the Act; nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the SCLAHIGA.

COVERAGE

Generally, individuals will be protected by the SCLAHIGA if they live in this state and hold a covered life, accident, health or annuity policy, plan or contract issued by an insurer (including a health maintenance organization) authorized to conduct business in South Carolina. The beneficiaries, payees or assignees of insured persons may also be protected if they live in another state unless circumstances described under the Act exclude coverage.

EXCLUSIONS FROM COVERAGE

Persons who hold a covered life, accident, health or annuity policy, plan or contract are r1ot protected by SCLAHIGA if:

- They are eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);
- The insurer was not authorized to do business in this state; or
- They acquired rights to receive payments through a structured settlement factoring agreement.

SCLAHIGA also does not provide coverage for:

- A portion of a policy or contract or part thereof not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;
- A policy or contract of reinsurance, unless assumption certificates have been issued;
- Interest rate or crediting rate yields or similar factors employed in calculating value changes that exceed an average rate;
- Any policy or contract issued by assessment mutuals, fraternals, and nonprofit hospital and medical service plans;
- Benefits payable by an employer, association or other person under: (a) a multiple employer welfare arrangement; (b) a minimum premium group insurance plan; (c) a stop-loss group insurance plan; or (d) an administrative services contract;
- A portion of a policy or contract to the extent that it provides for (a) dividends or experience rating credits; (b) voting rights; or (c) payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;
- A portion of a policy or contract to the extent that the assessments required by Section 38-29-80 with respect to the policy or contract are preempted by federal or state law;
- An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation: (a) Claims based on marketing materials; (b) Claims based on side letters, riders or other documents that were issued by *the* member insurer without meeting applicable policy or contract form filing or approval requirements; (c) Misrepresentations of or regarding policy or contract benefits; (d) Extra-contractual claims; or (e) A claim for penalties or consequential or incidental damages;
- An unallocated annuity contract;
- A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C or D or Medicaid; or
- Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNTS OF COVERAGE

The South Carolina Life and Accident and Health Insurance Guaranty Association Act also limits the amount that SCLAHIGA is obligated to pay for covered claims. The benefits for which SCLAHIGA may become liable shall in no event exceed the lesser of the following:

- With respect to one life, regardless of the number of policies or contracts: $300,000 in life insurance death benefits, or not more than $300,000 in net cash surrender and net cash withdrawal values for life insurance;
- For health insurance benefits: (a) $300,000 for coverages not defined as disability income insurance or health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values; (b) $300,000 for disability income insurance; (c) $300,000 for long-term care insurance; (d) $500,000 for health benefit plans; or
- $300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

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

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ąąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)

Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)

Notes

As your health plan, we're here to help you. If you need more information, assistance or have other questions, please:

Visit our website:
www.BlueChoiceSC.com
and send a secure email
through My Health Toolkit

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

Call Monday – Friday
from 8:30 a.m. – 5 p.m.:
800-868-2528
TTY Services 711 + 800-868-2528

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.

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

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