2025 Choice Level Funded Member Guide

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

Table of Contents

Welcome to BlueChoice HealthPlan 1

Your ID Card 3
- Advantages of Your Digital ID Card 3
- How To Access Your Digital ID Card 3

Accessing the Choice Level Funded Network 4
- Continuation of Care 5
- Choice Level Funded Network Benefits 5

Benefit Basics 7
- At-a-Glance Charts 7

Information on the Web 9
- My Health Toolkit® 9
- Download the My Health Toolkit Mobile App Today 9
- Get Our Texts 9

Plan Overview 10
- Urgent Care 10
- What We Pay For 10
- Out-of-Network Benefits 10
- Special Out-of-Network Rules 11
- What We Do Not Pay For 11
- Services and Supplies We Don't Cover 11
- Excluded Services 12

All-Inclusive Office Visit Copayment 13

Preventive Care and How To Stay Healthy 14
- Coverage for Preventive Exams and Screenings 14
- Preventive Health Guidelines 14

Value-Added Benefits and Services 14
- Employee Assistance Program 14
- Blue365® Discounts 15
- Vision (Pediatric and Adult) 16
- Dental Care 17
- Dental Reimbursement Form 18
- **FOCUS***fwd*® Wellness Incentive Program 20
- Stay Connected With the **FOCUS***fwd* App 21
- **FOCUS***fwd* GET FIT 22
- Track Your Physical Activity 23
- Personal Health Assessment (PHA) 24
- Health Management Programs 25
- My Health Novel℠ 26
- Behavioral Health Resources 26
- My Diabetes Discount Program 27

Help Wanted 28

Visit With a Doctor Anytime, Anywhere 29
- Services Available With Blue CareOnDemand℠ 29
- Get Started Now 29

Health Insurance Portability and Accountability Act (HIPAA) 30
- Authorization To Disclose to a Third Party Form 32

If You Need To See a Doctor 34
- Your Personal Physician 34
- Routine Care 34
- Gynecologist (GYN) 34
- If You Need To See a Specialist 34
- Other Health Care Providers 34

If You Need Urgent Care 35

If You Need To Be Admitted to the Hospital 35

If You Need Emergency Care 36

When Is an Emergency Not an Emergency? 37

If You Need a Prescription Drug 38
- What Is a Covered Drug? 38
- How We Cover Drugs 38

Can Covered Drugs Change? 40
- What if My Drug Is Not Covered? 40

Additional Pharmacy Considerations 40
- For More Information 40

If You Need Other Services 40
- Lab Work, X-Ray Studies and Pathology 40

If You Need Emergency Care Outside of Your Service Area 41
- In the United States 41
- Around the World 41

When You Need To Know What You Will Pay 42

Claims, Coverage and Payment Concerns 43
- Explanation of Benefits 43
- Submitting Claims 43
- If You Receive a Bill 43
- Coordination of Benefits 44
- Verification of Incapacitated Dependent 44

Policies and Procedures 45
- Administering Benefits for Appropriate Services 45
- Appeals and External Review Procedures 45
- Covering New Technology 46
- Authorization To Disclose Protected Health Information 46

Notice of Our Privacy Policies and Practices 48

Rights and Responsibilities 52

Glossary 53

SC Guaranty Association Act Notice 56

Foreign Language Access 58

Welcome to BlueChoice HealthPlan

This is your BlueChoice HealthPlan Member Guide, which outlines some of your benefits and covered services. Please refer to the Benefit 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
PO 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, or sex in the administration of the plan, including enrollment and benefit determination.

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**.

Plan of Benefits: This is an in-depth description of covered services, exclusions, limitations and eligibility requirements. You can find your Plan of Benefits 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 **Benefit Booklets** link to view the document. You can also request a copy of your Plan of Benefits 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 20 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 pages 53 – 54. Thank you for choosing BlueChoice®.

Your ID Card

Keep your Choice Level Funded ID card with you at all times. You will receive your ID card in the mail. If you have single coverage, you will receive one ID card. If you have dependents and/or family coverage, you will receive two cards. The ID cards will only include the primary cardholder's name, but all covered members can use them. You can also order additional cards if needed. Your ID card is specific to your health plan. Once you receive the card, you can begin using it the first day your plan is effective. Whenever you need medical care, be sure to show your ID card to the health care provider.

Your ID Card Is Digital, Too

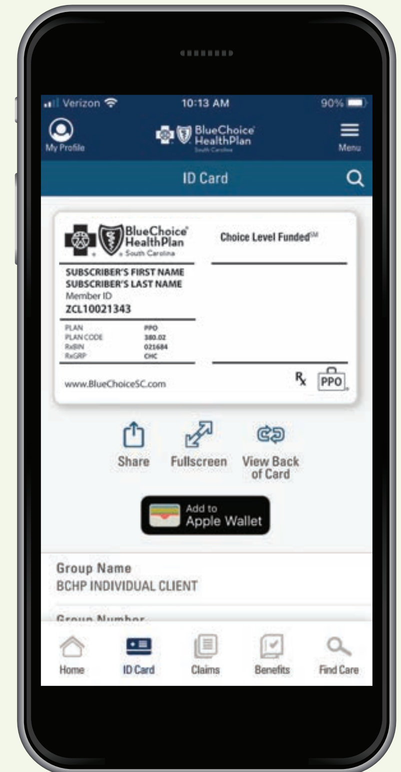
You can access your digital ID card anytime, anywhere from your computer or mobile device.

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. Your ID card will auto-download to your smartphone after your first log in to the My Health Toolkit app. This way, you can access it in case you are somewhere that has limited to no service. See page 9 for additional information about the My Health Toolkit app.

You can easily:

- View your card on your smartphone, tablet or computer.
- Share your card with 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 card, log in to your **My Health Toolkit** account and select **ID Card** at the top. To learn more about My Health Toolkit and how to log in or create a new account, see page 9.

Don't discard your physical ID card. Some doctors may still want a copy of it for their records.

App Store
Google play

Accessing the Choice Level Funded Network

Your plan offers a wide and comprehensive network of doctors, hospitals and other health care providers. This means you can receive your health care services from providers in this network.

We encourage you to select a primary care physician (PCP) but don't require you to select one. Once you have selected a PCP from the Choice Level Funded network, call his or her office to schedule an appointment for your routine checkup. Remember to bring your ID card with you each time you visit your PCP. If you are not currently a patient of the physician you choose, please call his or her office to make sure the physician is accepting new patients. We require all PCPs in our Choice Level Funded network to have 24-hour telephone service and another physician on call if he or she is unavailable.

You can access the full listing of doctors, hospitals and other health providers, including PCPs, in the Choice Level Funded network by visiting **www.BlueChoiceSC.com/FindCare**. You can call or write us to request a full directory with this information. The directory also includes professional qualifications of practitioners, such as medical school attended, residency completed and board certification status. If your current doctor is not in the Choice Level Funded network and you are in a treatment plan that began before your effective date, we encourage you to coordinate with Choice Level Funded network physicians to avoid disruption of care. You can do this by filling out and submitting a Transition of Care form.

Continuation of Care

If benefits under this plan are no longer covered for a provider due to a change in the provider's terms of participation in the network — such as the network provider's contract with BlueChoice or Companion Benefit Alternatives (CBA) is modified, it ends or is not renewed for any reason other than fraud or failure to meet specified quality standards, including suspension or revocation of the provider's license, or the contract is terminated — and you are a continuing care patient of the provider at the time, you may be eligible to receive network benefits for that provider's services for a limited period of time. We will attempt to notify you if and when these situations arise with your providers and explain your right to elect continued network coverage, but such continued network coverage is not automatic. Please contact us, or have your provider contact us, to receive the continued network coverage.

We recommend you use a form for this request. This form can be found by going to the website at **www.BlueChoiceSC.com** or calling the number on the back of your member ID card. Your treating physician should include a statement on the form confirming that you have a serious medical condition. Upon receipt of your request, we will confirm the last date the provider is part of our network and provide a summary of continuation of care requirements. If additional information is necessary, we may contact you or the provider.

If you qualify for continued in-network status, we will provide in-network benefits for you from that provider for the course of treatment relating to your status as a continuing care patient for 90 days or until the date you are no longer a continuing care patient with respect to the provider, whichever occurs earlier. Such continued network status is subject to all other terms and conditions of the contract, including regular benefit limits.

Choice Level Funded Network Benefits

We contracted with a network of doctors, hospitals and other health care professionals to provide services to you.

Choice Level Funded 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.

Benefit Basics

IF YOU NEED TO:	THE BASIC ANSWER:	FOR MORE INFORMATION:
Get an overview of your plan	The Choice Level Funded plan gives you the flexibility to choose where you receive medical care. You have benefits for in-network (participating) and out-of-network providers. We provide coverage for medically necessary services we list as covered in your Schedule of Benefits and your Plan of Benefits. You should also check your Plan of Benefits to see any exclusions or limitations. This can be found when you log in to 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 **Benefit Booklets** link to view the document. Remember to show your member ID card whenever you get medical services.	p. 9
Get information online	**www.BlueChoiceSC.com** and My Health Toolkit make navigating your health plan a breeze! You can search for an in-network provider, check your claims status and authorizations, find a particular prescription drug, get information about our wellness programs, and so much more.	p. 12
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.	p. 13
Get help managing a chronic condition or reaching a health goal	Your health plan comes with free telephonic visits with a care manager. Our care managers specialize in supporting people with conditions such as high blood pressure, diabetes, high cholesterol and asthma. We also have programs for those who want to lose weight, those who want to quit smoking or learn to manage stress, and those with chronic back pain.	p. 25
See a doctor	Your plan allows you to see a PCP or specialist within the Choice Level Funded network without getting prior approval (authorization). We strongly recommend, however, that you have one doctor who knows you and your medical history and can coordinate care with specialists and other providers.	p. 34
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.	p. 35
Be admitted to the hospital	You must get all inpatient care authorized in advance, except for emergency admissions. When you use a Choice Level Funded network hospital, your doctor and the hospital will coordinate this for you. See your Schedule of Benefits to find out more about inpatient deductibles and coinsurance.	p. 35
Get emergency care	If possible, call your physician. If there's no time to do that, call and/or get to the nearest emergency room (ER) for care. It must be an emergency medical condition for you to have coverage at an ER. See your Schedule of Benefits to find your ER copayment.	p. 36
Get a prescription drug	You have prescription drug benefits with BlueChoice. Your ID card is also your prescription card. Take your ID card and your prescription to any network pharmacy and you can buy up to a 90-day supply. You can also fill mail-order prescriptions up to a 90-day supply. You can buy specialty drugs up to a 30-day supply and purchase them through our preferred specialty pharmacy. We cover most drugs under your plan. There are six tiers of coverage levels, including specialty drugs. See your Schedule of Benefits to find your cost (copayment or deductible and/or coinsurance) for each of these drug tiers.	p. 38
Get emergency care anywhere	With the BlueCard® network, you have access to emergency services wherever you go.	p. 41

IF YOU NEED TO:	THE BASIC ANSWER:	FOR MORE INFORMATION:
Know how much you'll pay	Each plan has its own level of copayments, deductibles, coinsurance and maximum out-of-pocket (MOOP) expenses. Your Schedule of Benefits lists what you will pay for different services. You can also find cost estimators and drug cost comparisons on our website.	p. 42
Learn about claims and other payment issues	You will receive an Explanation of Benefits (EOB) after a visit to your PCP, dentist, etc. EOBs are also available to you in My Health Toolkit. You also need to know about coordination of benefits (COB) and the required annual certification and other paperwork needed. You can also learn about how we keep our benefits current with the latest advancements in health technology.	p. 43
Understand policies and procedures and know your rights and responsibilities	As a BlueChoice member, you should understand all the "fine print" in your plan. You are also entitled to certain rights, including privacy and you have certain responsibilities as a member. You also can appeal certain decisions.	pp. 48, 52
Learn insurance terms	Check out the glossary for a definition of any words you don't fully understand.	p. 53

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.

when you register for My Health Toolkit

With My Health Toolkit, you can:

- Find doctors, hospitals, dentists and other health care providers.
- Access Blue365 discount programs (page 15).
- 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!

Download the My Health Toolkit Mobile App Today

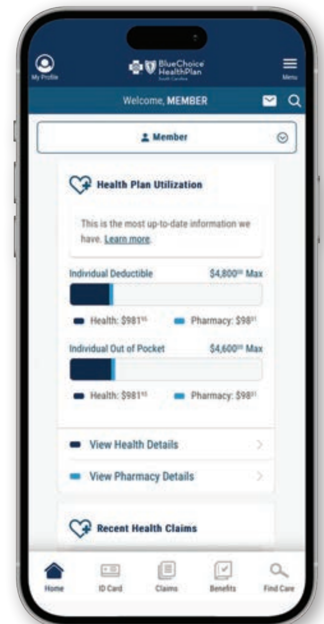
Your insurance benefits are with you wherever you go and whenever you need them.

With the app, you can:

- View and share your digital ID card.
- See what's covered by your health plan.
- Update your contact information.
- Quickly check the status of your claims.
- Find an in-network doctor or hospital.

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:

- Important plan updates
- Health and wellness reminders
- Ways you can save

... and more!

You can sign up when you register for My Health Toolkit. If you already have an account, you can update your contact information by going to **Profile**, then **My Account** and selecting **Contact Information**.

when you sign up to receive text messages

Plan Overview

When you need medical care, we encourage you to find a provider in the Choice Level Funded network. You can find a provider in two ways: Visit **www.BlueChoiceSC.com/FindCare** or contact Member Services. The directory on the web helps you find participating medical professionals in the Choice Level Funded network. This network provides you with quality providers who can minimize costs while administering quality care.

Urgent Care

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 or contact Member Services.

What We Pay For

We cover services that are medically necessary and that your plan lists as covered. See your Schedule of Benefits and Plan of Benefits, which can be found when you log in to your My Health Toolkit account. We pay for covered services you receive only while you are a member of BlueChoice.

Out-of-Network Benefits

If you choose to see a provider that is not in our network, your out-of-network benefits will apply. Out-of-network benefits provide a lower level of coverage and allowance on services than in-network benefits. This means that you may have to pay higher copayments or coinsurance than you do with your in-network benefits. You can also be billed for any amount in excess of the allowable charge, except where prohibited by applicable law. In addition, you are responsible for completing claim forms and submitting itemized bills to receive your benefits. You have 12 months from the date of service to submit forms.

Remember: BlueChoice must approve in advance all inpatient admissions except emergency admissions. In-network providers are familiar with the requirement and will obtain approval for you. For emergency admissions or if visiting an out-of-network provider, you or someone acting on your behalf must notify BlueChoice no later than 24 hours after the admission or the next working day, whichever is later. Some services covered by in-network benefits may not be covered by out-of-network benefits.

Special Out-of-Network Rules

If you receive treatment from an out-of-network provider as described, your treatment may be covered and your costs may be covered under the same terms as if the treatment had been received from an in-network provider, and the allowed amount will be the recognized amount. This exception applies only if one of the following situations applies. You will still be liable for any in-network cost share amounts under all other terms of this coverage. These are the only circumstances in which BlueChoice will allow for out-of-network services without prior authorization and approval:

- You are treated in the emergency department of a hospital or a free-standing emergency department where the facility or a treating provider is not in-network, including post-stabilization services provided as part of outpatient observation or an inpatient or outpatient stay with respect to the emergency department visit where emergency services were furnished. In emergency situations, no prior authorization is required. For post-stabilization services, the provider or facility may furnish you with a notice of treatment by a nonnetwork provider and opportunity to consent to the treatment, in which case this section will not apply to those post-stabilization services.
- You seek nonemergency treatment at an in-network hospital, hospital outpatient department, critical access hospital or ambulatory surgical center, but during your treatment, you receive services from a nonnetwork provider. An example of this would be if you have surgery performed in a network hospital; your surgeon is in our network, but the anesthesiologist is out of network. Except for certain ancillary services, and other items and services furnished due to unforeseen, urgent medical needs, when this occurs, the provider may furnish you a notice of treatment by a nonnetwork provider and an opportunity to consent to the treatment, in which case this section will not apply to those services.
- It is medically necessary for you to be transported by an air ambulance company not in our network.

If you need assistance because one of these actions has occurred, please contact us using the information on the back of your ID card or by one of the methods outlined on page 1.

What We Do Not Pay For

Please refer to your Plan of Benefits for a full list of services not covered under your plan. You can find this by logging in to your My Health Toolkit account and selecting **My Plan & Benefits**, followed by **Health**, then **Health Benefits**. Services we don't cover are called exclusions. Services with restrictions are called limitations. You will be responsible for payment of noncovered services. See a partial list of excluded services on page 12.

Services and Supplies We Don't Cover

We don't provide benefits for these items unless otherwise specified in the Schedule of Benefits or in the Plan 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 the Plan of Benefits, even if medically necessary, we will not provide benefits for:

- Services and supplies that aren't medically necessary or not needed for the diagnosis or treatment of an illness or injury.
- Services or supplies for which you're entitled to benefits under Medicare or any other governmental program, except for Medicaid, or for which you're not legally responsible for paying.
- Benefits for injuries or diseases paid by workers' compensation or settlement of a workers' compensation claim.
- Any charges by the Department of Veterans Affairs (VA) for a service-related disability or care in any state or federal hospital for which you aren't legally responsible.
- Admissions or portions thereof for long-term care, including 1) rest care; 2) care to assist a member in the performance of activities of daily living, including but not limited to walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication; 3) custodial or long-term care; or 4) psychiatric or substance use disorder treatment, including but not limited to therapeutic schools, wilderness/boot camps, therapeutic boarding homes, halfway houses and therapeutic group homes.
- Treatment resulting from war or acts of war (whether declared or undeclared), while participating in a riot or uprising or while in the military service or its auxiliary units.
- Any loss that results from you committing or attempting to commit a crime, felony or misdemeanor, or from engaging in an illegal occupation.
- Any services or supplies a member of your family provides, including the dispensing of drugs. A member of your family means spouse, parents, grandparents, brothers, sisters, aunts, uncles, children or in-laws.
- Services and supplies related to cosmetic surgery, as determined by us. 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.
- Eyeglasses, contact lenses (except for cataract surgery), except as shown in covered services, and hearing aids and exams for the prescription or fitting of them. Any hospital or physician charges related to refractive care, such as radial keratotomy (surgery to correct nearsightedness), keratomileusis (laser eye surgery), lamellar keratoplasty (corneal grafting) or any such procedures that are designed to alter the refractive properties of the cornea.
- Services or supplies related to abortions not complying with applicable law.
- Physician services directly related to the care, filling, removal or replacement of teeth; the removal of impacted teeth; and the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. Exception is made, as shown in Covered Services, for dental treatment to sound natural teeth for up to six months after an accident and for medically necessary cleft lip and palate services.
- Separate charges for services or supplies from an employee of a hospital, laboratory or other institution or from an independent health care professional whose services are normally included in facility charges.
- Services, procedures, charges, supplies, equipment or pharmaceuticals for which prior 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.

For a complete list of exclusions and limitations for your Choice Level Funded plan, please review the Plan of Benefits.

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 that if you visit a network provider, you will pay one copayment for all diagnostic and treatment services performed in the office. Services are not limited to routine and sick visits. They also 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.

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 Choice Level Funded 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, 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. These Preventive Health Guidelines are located in the **Member Center** section under the **Keys to Using Your Coverage** tab, or you can contact Member Services for more information.

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:

- 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

Note: Any costs associated with EAP are not applicable to your deductible or out-of-pocket expenses.

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

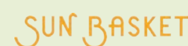
You can take advantage of great discount programs and special services with **Blue365***, a program offering nationwide discounts. We offer these services and discounts to our members in addition to, but not included in, the services and benefits covered under your policy. Through our value-added services,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

- Discounts on fitness equipment such as Garmin® activity trackers, weight loss programs, fitness centers, and other health and wellness supplies
- Discounts on footwear from popular 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

for registering for Blue365

You can access these deals and more by logging in to your My Health Toolkit account and selecting **Blue365**.

Exclusive savings from



These vendors are independent companies that offer discounts to members of BlueChoice HealthPlan. These discounts are not covered benefits under your plan.

*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.

Vision and Dental Coverage

We have value-added benefits and services for all Choice Level Funded plans. See the glossary on pages 54 – 55 for a definition of maximum out of pocket (MOOP) and other health insurance terms.

Our plans include routine adult and pediatric vision coverage through EyeMed. You have access to the right mix of in-network providers — including independent eye doctors and popular retailers such as LensCrafters®, Target Optical® and Pearle Vision®. You can even use your benefits online at **Glasses.com**, **ContactsDirect.com**, **LensCrafters.com**, **TargetOptical.com**, **Ray-Ban.com** and **Oakley.com**. Good vision is important. That's why we stay focused on eye care.

Adult Vision Care

For adult vision care, you get:

- A $0 copayment for one routine eye exam every benefit year.
- Up to $40 for one standard contact lens fitting or 10 percent off the provider's nonstandard contact lens fitting fee per benefit year.
- A $120 material allowance with $0 copayment every two benefit years for glasses or contacts, with no limits on frame or lens selection.
- A 40 percent discount on an additional complete pair eyeglass purchase and a 15 percent discount on conventional contact lenses once the funded benefit has been used.

Please note that you must visit a provider in the EyeMed network to receive this benefit. Costs incurred from these services do not count toward MOOP expenses. These benefits are nonessential.*

To locate an in-network eye doctor, please visit **www.BlueChoiceSC.com/FindCare**.

*Nonessential benefit: Any benefit provided that is not considered an essential health benefit is a nonessential benefit.

Pediatric Vision*

For children (ages 0 – 18), this includes:

- A $25 copayment for one routine eye exam every benefit year.
- Up to $40 for one standard contact lens fitting or 10 percent off the provider's nonstandard contact lens fitting fee per benefit year.
- A $50 copayment, then 100 percent coverage for provided designated frames, once every benefit year.
- A 40 percent discount on an additional complete pair eyeglass purchase and a 15 percent discount on conventional contact lenses once the funded benefit has been used.

Please note for pediatric vision, you must visit a provider in the EyeMed network to receive this benefit. Costs incurred from these services count toward maximum out-of-pocket (MOOP) expenses. These benefits are essential.**

*For dependent children through the age of 18. Adult vision care begins on the first day of the month following their 19th birthday.

**Essential benefit: A set of 10 categories of services health insurance plans must cover under the Affordable Care Act. These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more. Any benefit provided that is not considered an essential health benefit is a nonessential benefit.

EyeMed is an independent company that offers a vision network on behalf of BlueChoice.

Dental Care

Start smiling, because our plans include a reimbursement for preventive care, which includes exams and cleanings from a licensed dentist.

Adults (ages 20 and up) and children (ages 19 and under) receive:

- One exam every six months: $50 allowance for initial/$50 allowance for periodic.
- One cleaning every six months: $50 allowance.

You will be responsible for paying any additional balance above what we cover. You will need to submit a dental reimbursement form with a bill or receipt from the dentist to BlueChoice for reimbursement. See the next page for the form.

For example, if your dentist charges you $130 for an initial cleaning and exam, you will pay your dentist $130 at the time of service. We will reimburse you $100 once we receive your reimbursement form. If you need an additional form, please visit **www.BlueChoiceSC.com** and select **Find a Form**. Any costs associated with dental services are not applicable to the deductible or maximum out-of-pocket (MOOP) expenses.

Dental Reimbursement Form

Patient's Name: ______________________________ Sex: ☐ Male ☐ Female

Patient's Birthdate: _____/_____/_____
MM DD YY

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Name: ______________________________

Insured's ID Number: ______________________________

Patient's Address (No., Street): ______________________________

City: ______________________________ State: ______________________________

ZIP Code: ______________________________ Telephone: (   ) ______________________________

Date(s) of Service From: MM DD YY	To: MM DD YY	Description of Item or Service	Amount Paid	Procedure Code

Provider's Name: ______________________________

Provider's Address (No., Street): ______________________________

City: ______________________________ State: ______________________________

ZIP Code: ______________________________ Telephone: (   ) ______________________________

Please submit a bill or receipt with the provider's name and address. Include a complete description of services provided.

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

You have 12 months from the date of service to submit this form.

99835-6-2022

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.

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.

Get started:

1. Visit **www.BlueChoiceSC.com**.
2. Log in to **My Health Toolkit**.
3. Access 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!

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. Access the **FOCUS***fwd* **Wellness Incentive Program** from your My Health Toolkit account.
3. Select the **Learn More** button.
4. Follow the on-screen prompts to link your account to the **FOCUS***fwd* app.

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.

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. Access the **FOCUS***fwd* **Wellness Incentive Program**.
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. Follow the on-screen prompts to link your account to the **FOCUS***fwd* app.

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.

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 privacy 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.

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! Best of all, you can participate in these programs at no cost.

We offer these programs for education and support:

Prevention and Wellness

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

Behavioral Health

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

Condition Support

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Kidney Disease
- Diabetes
- Heart Disease
- Heart Failure
- High Blood Pressure
- High Cholesterol
- Metabolic Health
- Migraine
- Neonatal Intensive Care Unit (NICU) Case Management

for participating in select Great Expectations

For more information or to enroll in a Great Expectations program, you can call us at **855-838-5897** or visit our **Great Expectations** page.

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, musculoskeletal health and digestive 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

Behavioral Health Resources

Few things affect us as much as our mental health. It can influence our self-esteem, work, family life and physical well-being. If you struggle with your mental health, you are not alone. BlueChoice HealthPlan of South Carolina offers a wide range of options that can help.

Companion Benefit Alternatives (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** or visit the **Behavioral Health Resources** page on our site.

Also, **Blue CareOnDemand** Powered by MDLIVE (see page 29) 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 by logging in to your **My Health Toolkit** account through our website or by using the My Health Toolkit app. Cost of Blue CareOnDemand visits varies by visit type and provider selected, and it is subject to plan benefits.

Check out the **Behavioral Health Resources** page to learn more about our behavioral health benefits.

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.

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, 2025, through March 31, 2026.

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.

HELP WANTED

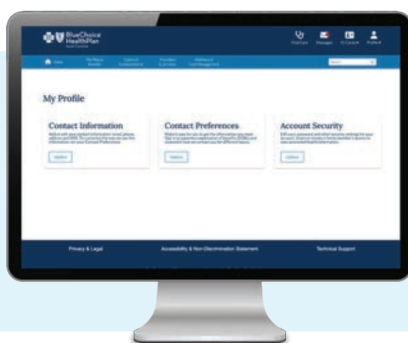
BlueChoice HealthPlan needs **your** help!

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:

- Important plan updates
- Health and wellness reminders
- Ways you can save … and more!

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.

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

MDLIVE is an independent company that provides a telehealth platform on behalf of BlueChoice HealthPlan. Copyright © 2024 MDLIVE Inc. MDLIVE and the MDLIVE logo are registered trademarks of MDLIVE Inc.

Health Insurance Portability and Accountability Act (HIPAA)

BlueChoice has always had a commitment to protecting your confidential health information. HIPAA is a federal law that changes the way we use and release information about you.

As of April 13, 2003, we cannot give your protected health information (PHI) to another person unless we have legal permission. What does this mean? If you want to let your spouse, family member or close friend contact us for your claims or payment information, we can't release it to him or her unless you have given us permission. You must give us your permission in writing.

For your convenience, we have created a form to grant authorization. You can use this form to give us permission to release information to someone else. You don't have to complete and return this form unless you want someone other than yourself to receive your PHI. Please note that if you're a parent of a minor child (under the age of 16), you can still get information about your child without having to complete this form.

If you'd like to complete the form, please use the one on the next page. Please complete all required information and mail it to:

BlueChoice HealthPlan
Attn: Privacy Official (AX-400)
PO Box 6170
Columbia, SC 29219

If you'd like to learn more about how we protect your health information, please review our privacy practices on page 48.

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

BCHP Authorization 10/2023

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)

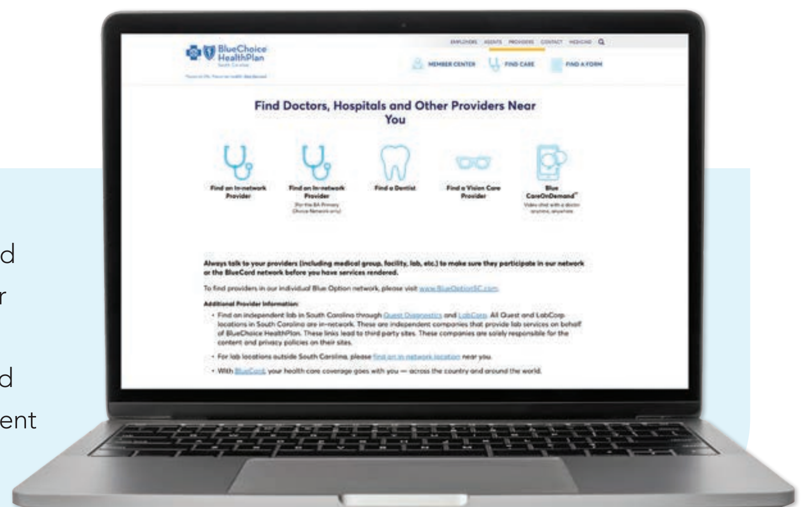
We provide benefits for women to receive regular, preventive care. If you go to a GYN who is part of our network of doctors, we cover your routine exam at the in-network benefit level. We also cover routine exams by your PCP. Be sure to confirm coverage levels in your Schedule of Benefits.

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 network provider of your choice.

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 participating network specialists, you will have in-network benefits for services your plan covers.



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, visit **www.BlueChoiceSC.com/Find-Care** or contact Member Services (see Welcome page for contact information).

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 Plan of Benefits. 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.

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

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 Powered by MDLIVE 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 29.

If You Need a Prescription Drug

Your plan includes prescription drug coverage. You can find covered drugs via the Prescription Drug Tool, and a list of network pharmacies in South Carolina, quickly at **www.BlueChoiceSC.com/Choice-Level-Funded-Pharmacy-Benefits**. Certain prescription drug coverage services are administered by Optum Rx®, an independent company that provides pharmacy benefit management on behalf of your health plan.

What Is the Prescription Drug List?

These are drugs that we cover under your Choice Level Funded health plan. BlueChoice works with a team of health care providers to choose drugs that provide quality treatment. We cover drugs 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

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

Your plan includes limits and requirements for coverage of certain drugs. These requirements and limits may include:

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.

Specialty Pharmacy: 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.

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 count toward the member's annual limitation on cost sharing. The drug will still be considered a covered prescription drug.**

Prior Authorization: If your drug needs prior authorization, your doctor will have to get approval before we will cover your drug. There are different reasons a drug might require prior authorization. One is to make sure it's being used for the condition(s) it was approved for by the U.S. Food and Drug Administration (FDA). Another reason is because there are drugs that usually work just as well but will cost you less. Please note that compound drugs require prior authorization.

Quantity Limits: If your drug has a quantity limit, we will only cover a certain amount of the drug in a specified period of time, usually a month. This is to make sure you are using the drug safely and based on FDA guidelines.

Step Therapy: If your drug has a step therapy requirement, we will only cover second-choice drugs if you have already tried a first-choice drug and it didn't work for you. The reason for a particular step therapy requirement may be because there are drugs that usually work just as well but will cost you less. It may also be because the FDA approves some drugs specifically as second-choice drugs or as add-ons to other medications.

If we determine a member has used multiple doctors or pharmacies to obtain quantities of prescription drugs in excess of what is allowed or recommended, we reserve the right to require the use of a designated provider for prescribing the medication and/or a specific pharmacy to fill all prescriptions for that medication.

You can ask us to remove coverage restrictions or limits on your drug. For example, BlueChoice limits the amount of certain drugs that we will cover. If your drug has a quantity limit, you can ask us to remove the limit and cover more. Generally, BlueChoice will only approve your request for an exception if the preferred drugs included on the list of covered drugs are not as effective in treating your condition or if they cause you to have adverse medical effects. To request an exception to a prior authorization, quantity or step therapy requirement, you or your doctor can call the Member Services number on the back of your ID card.

Can Covered Drugs Change?

Drugs that are covered may change from time to time. Refer to the **Choice Level Funded Pharmacy page** for the most recent information.

What if My Drug Is Not Covered?

If your drug is not on this drug list, call Member Services to make sure your drug is, in fact, not covered. If you learn we do not cover your drug, you can 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 that is covered. Similar drugs that are preferred may be easier to get and cost you less than nonpreferred drugs.

Additional Pharmacy Considerations

Generic and brand-name maintenance drugs are available for a 90-day supply through the **mail-order** program. Mail service is ideal if you take prescription drugs on a regular basis. Please refer to your Summary of Benefits for more information about what you'll pay for your mail-service prescriptions. If you are new to mail service, you will need a new prescription from your doctor. You can mail in the prescription along with a mail service form you can find on our website. Or your doctor can submit your prescription directly to a home delivery pharmacy. Certain drug categories, such as weight loss and erectile dysfunction drugs, are excluded from your coverage. Please see your member policy for a complete list of these exclusions.

For More Information

For more information about your prescription drug coverage, please check out the Prescription Drug Tool at **www.BlueChoiceSC.com**. If you have questions about your plan or the drug list, please call Member Services at the number on the back of your ID card.

If You Need Other Services

Lab Work, X-Rays and Pathology

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

If You Need Emergency Care Outside of Your Service Area

You have access to doctors and hospitals worldwide through the BlueCard network. If you use a provider who participates in the preferred provider organization (PPO) network, we will pay emergency services at the in-network percentage.

In the United States

- Always carry your current member ID card.
- Always use a BlueCard PPO doctor or hospital to ensure you receive the highest level of benefits.
- 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. The provider will identify your benefit level through one of these symbols:

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 prior authorization. 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.

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 Choice Level Funded network provider.

There are 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:** A specific amount of money you pay for certain services, such as office visits or medications, each time you use that service, as your plan defines. 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.
- **Coinsurance:** A percentage of the allowed amount that you pay. This percentage applies to the negotiated rate or lesser charge when we've negotiated rates with that provider. For example, you pay 20 percent of the allowed amount, and we pay 80 percent.
- **Deductible:** The amount of medical expenses you 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 covered medical services within 12 successive months before your health plan would begin reimbursing for covered services.
- **Allowed Amount:** The dollar amount that a health plan determines is appropriate for a covered service.

In addition to the possible charges listed, your doctor may recommend you receive a service 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.

Claims, Coverage and Payment Concerns

Explanation of Benefits

We send a Summary Explanation of Benefits (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 may owe or have paid the provider" box on your EOB. You can also access your EOBs by visiting **www.BlueChoiceSC.com** and logging in to **My Health Toolkit**.

Submitting Claims

If an out-of-network provider provides services, you may be required to pay upfront for your services and submit a member claim form for reimbursement. Please contact Member Services if you have any questions.

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

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 more than one group health plan covers you, 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.

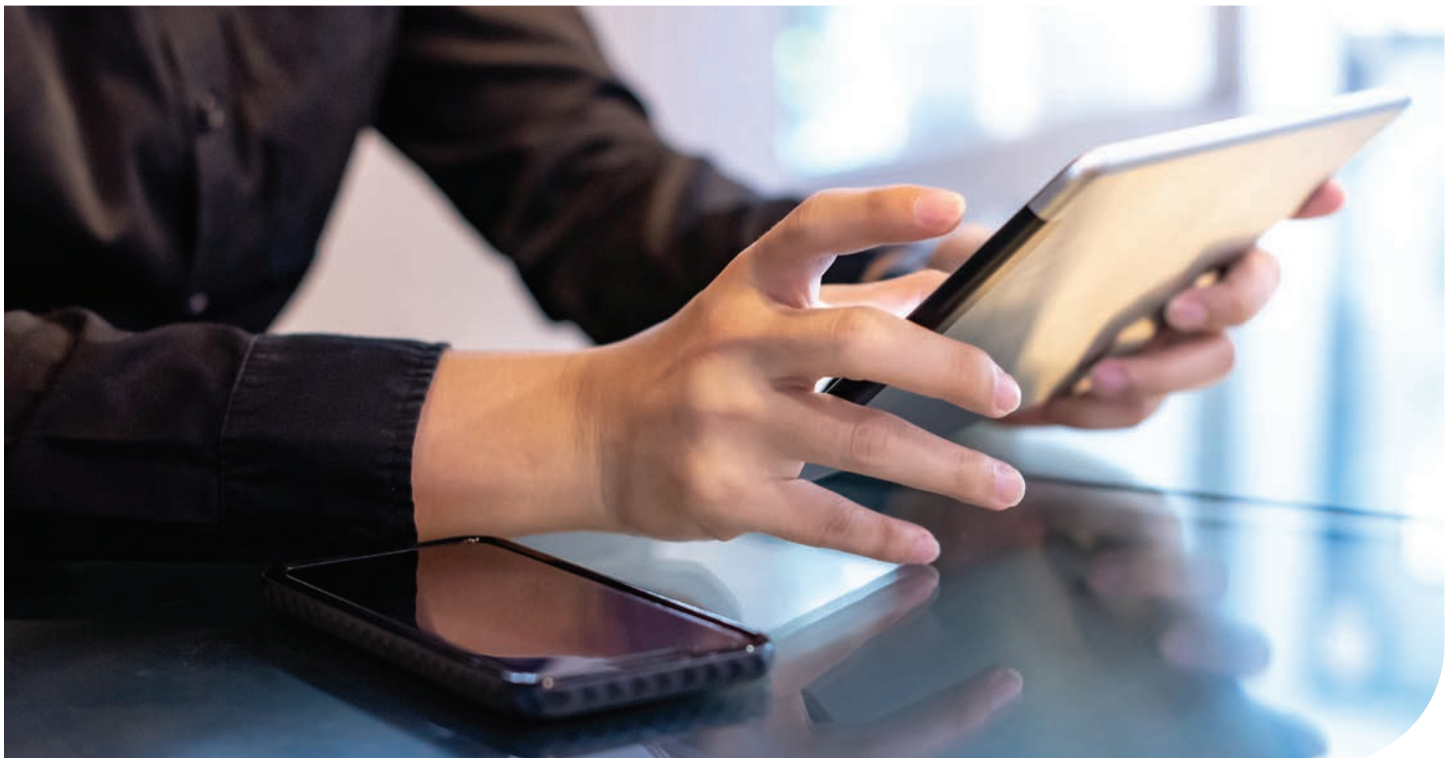
Since an individual's health care coverage can change frequently, we will send you a questionnaire once a year asking if you have other health care coverage. We will use the information you provide to determine which plan should pay first. Please take a moment to complete the questionnaire and return it to us so we can process your claims 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. To keep coverage for an incapacitated depen dent, you must give us written proof of the disability from a physician within 31 days of the dependent's 26th birthday. Records must reflect the dependents current medical condition, including an evaluation within the last 12 months. For the child to remain covered, we may request a physician's written report no more often than every two years. Coverage must also remain in effect for you. An incapacitated dependent is a child that is: 1) incapable of self-sustaining employment because of a behavioral health illness or physical handicap; and 2) mainly dependent upon you or your spouse for support and maintenance. The child must have developed the handicap before he or she reached the age of 26.



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 days 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

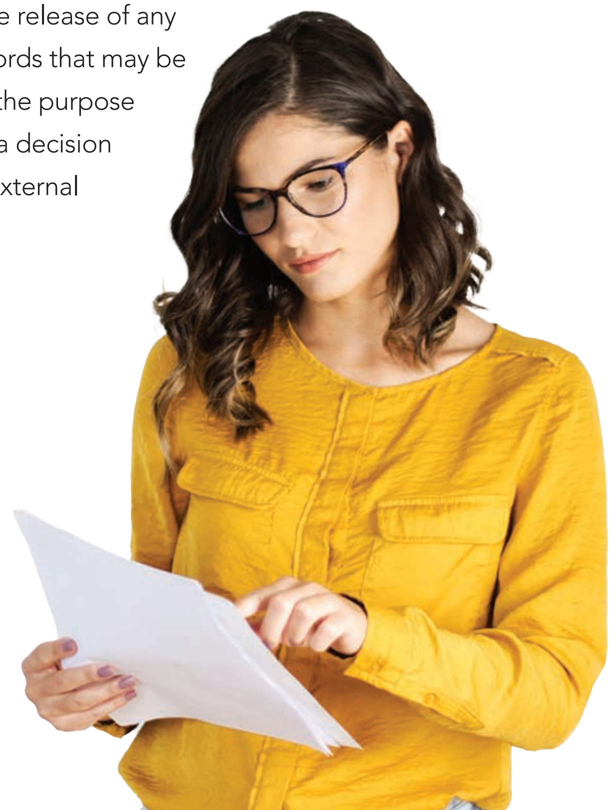
Once we receive the information, our Appeals department will conduct a complete investigation. You will be notified of our decision in writing within 30 days if a denial is being given before a service occurs or within 60 days if a service has already occurred.

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" or not 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. 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 either of these occurs:

- Your physician has certified in writing that you have a serious medical condition.
- 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.

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.

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 32 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.

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 activities related to payment such as:

- Paying claims from physicians, hospitals and other health care providers
- Obtaining premiums
- Issuing explanations of benefits to the named insured
- Providing information to health care professionals or other entities that are bound by the federal Privacy Rules for their payment activities

Health Care Operations: We may use or disclose your medical information in the normal course of conducting health care operations, including such activities as:

- Quality assessment and improvement activities.
- Reviewing the qualifications of health care professionals.
- Compliance and detection of fraud and abuse.

- Underwriting, enrollment and other activities related to creating, renewing or replacing a plan of benefits. We may not, however, use or disclose genetic information for underwriting purposes.
- Providing information to another entity bound by the federal Privacy Rules for its health care operations, in limited circumstances.

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

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

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

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

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

Your Authorization

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

Individual Rights

You have certain rights with respect to the medical information we maintain about you. To exercise any of these rights or to obtain more information about these rights (including any applicable fees), contact us using the information listed at the end of this notice.

Access

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

Disclosure Accounting

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

Restriction

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

Confidential Communications

You have the right to request, in writing, that we communicate with you about your medical information by other means, or to another location. We are not required to agree to your request unless you state that you could be in danger if we do not communicate to you in confidence. In that case, we must accommodate your request if it is reasonable, if it specifies the other means or location, and if it permits us to continue to collect premiums and pay claims under your health plan. We will not be bound to your request unless our agreement is in writing.

Even if we agree to communicate with you in confidence, an Explanation of Benefits we issue to the named insured for health care services the named insured (or others covered by the health plan) received might contain sufficient information (such as deductible and out-of-pocket amounts) to reveal that you obtained health care services for which we paid.

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

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

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

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)

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.
10. Members have the responsibility to follow the rules of their membership.

Glossary

Actual Charge — The amount a doctor or other health care provider actually bills a patient. You often see the phrase, "The actual charge may be different from the allowable charge." This means your health plan may only cover a portion of what your doctor charges you. For example, your doctor bills you $35 for an office visit. This is the actual charge. But your health plan may only accept $32 for an office visit. This is the allowable charge.

Allowable Charge — The most your health plan will pay for a covered service. You may see the phrase, "The actual charge may be different from the allowable charge." This means your health plan may only cover a portion of what your doctor charges you. For example, your doctor bills you $35 for an office visit. This is the actual charge. But your health plan may only accept $32 for an office visit. This is the allowable charge.

Approval — The process of deciding whether a person's health plan will cover a specific service. Check your health plan carefully. You may find certain procedures, like surgery, require preapproval. This means you need to check with your health plan to see if it will cover the service before you receive it. This simple approval process could save you money!

Approved Amount — The amount your health plan says is reasonable for a covered service. This amount may be l ess than the actual amount. For example, your health plan may cover $29 for a doctor's office visit even though your doctor may charge you $32 for that visit. The $29 is the approved amount.

Assignment — When you authorize your health plan to pay benefits to your health care provider instead of sending payment to you. Are you covered by BlueChoice? If you are, your benefits are automatically paid (assigned) to our network providers.

Benefit — Services and supplies a health plan pays for. The term also refers to the amount a health plan will pay.

Benefit Period — The period of time a health plan will pay for covered benefits. Benefit periods are usually one year. They don't always reflect a calendar year, so be sure and check your policy.

Case Management — A program that will pay for health care services your health plan usually will not cover if those services will help you get well faster or better. For example, a woman goes into premature labor and her doctor recommends a drug that will keep her from delivering the baby. Her health plan would not normally pay for this drug. But under case management, special members of the health plan's staff look at the woman's case. They realize if she were to have her baby early, the baby could risk its life and run up huge medical bills. So they cover the drug.

Coinsurance — The dollar amount or percentage you pay. For example, if you have an "80/20 plan," your health plan would pay 80 percent of the bill and you would pay 20 percent. The 20 percent you pay is your coinsurance.

Copayment — A fee you pay for each doctor's office visit, medical service or prescription. For example, your health plan may have a $10 copayment for doctor's office visits. This means every time you visited your doctor, you would pay just $10.

Cost Sharing — A method of dividing the cost of health care among consumers, insurance companies, employers and providers. For example, your employer may pay part of the premiums for your insurance. Your health plan will pay part of your health care bills, and you will pay part. If your doctor is part of your health plan's network, then he or she will cover part of the cost by negotiating a discount for his or her services. Everyone shares in the cost to keep costs down.

Covered Service — Specific services your health plan will pay for.

Deductible — The amount of money you must pay before your health plan will pay its share. For example, if you have a health plan with a $250 deductible, you must reach that amount before your health plan begins paying.

Emergency Medical Condition — A severe injury or illness (including pain). Your illness or injury must be so severe that if you don't get medical care right away, you face:

- Serious risk to your health. If you're pregnant, this includes your health and your unborn child's health.
- Serious damage to body functions.
- Serious damage to any organs or body parts.

Exclusion — Services or items your health plan doesn't cover.

Fraud — A deception that could result in your health plan paying for something it shouldn't. For example, if your doctor files a claim for a service you didn't receive, this is fraud.

Hospice — An organization that helps dying patients and their families. Staff members help relieve pain, manage symptoms and offer counseling to patients and their families.

Immunosuppressive Drugs — Medicine that people who have received organ transplants must take to help prevent their bodies from rejecting the new organs.

Maximum Out of Pocket (MOOP) — The MOOP is the most you pay during a policy period (usually one year) before BlueChoice HealthPlan starts to pay 100 percent for covered essential health benefits in-network providers provide. This limit must include deductibles, coinsurance, copayments and/or similar charges.

Open Access Plan — A health plan that lets you visit any doctor in the plan's network. You do not need a referral from your PCP.

Outpatient — A patient who gets treatment at a hospital but doesn't stay there. For example, you go to the hospital in the morning for minor surgery. As soon as you wake up from the anesthesia, the doctor sends you home to recover. This is outpatient care because you didn't need to stay in the hospital. There may be some cases when you spend the night in a hospital but still are considered an outpatient. It's always best to ask your doctor if you're getting outpatient or inpatient care, because your health plan may pay differently for each.

Primary Care Physician — A family doctor, general physician, OB-GYN, pediatrician, osteopath or internal medicine physician. This doctor will coordinate all your medical care. You can choose a family practitioner, an internist or a pediatrician. Your doctor, your health maintenance organization (HMO) and you form a team. You'll work together to find the right care to help you get healthy and stay well.

Referral — A referral is consent from your PCP to see a specialist for an illness or injury. You may also need a referral to have special treatments, such as X-rays or surgery. A referral saves you money by reducing unnecessary medical costs. Your PCP will decide if you need to see a specialist. He or she will help you choose a specialist that is right for you.

Specialist — A specialist is a doctor who treats certain illnesses or injuries. For example, a surgeon is a specialist. A doctor who treats allergies or heart problems is also a specialist. You may need a referral from your PCP to visit a specialist.

Urgent Care — Medical care for an illness or injury that is urgent but not life-threatening. You need urgent care to keep you from getting sicker or your injury from getting worse. Examples include deep cuts, severe diarrhea, ankle sprains, earaches, sore throats and fevers.

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.

Foreign Language Access

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.

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'ą́ą́h naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshį́į́ 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
PO 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, or sex in the administration of the plan, including enrollment and benefit determination.

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

BlueChoice HealthPlan is an independent licensee of the Blue Cross Blue Shield Association.

www.BlueChoiceSC.com

219512-BC-1221-12-2024