2024 Member Guide

Blue Option℠

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

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Welcome to BlueChoice HealthPlan

This is your Blue Option Member Guide. It outlines some of your benefits and covered services. If you need more detailed information concerning your benefits and covered services, please see your individual insurance contract. If you need more detailed information concerning any other topic, please read the expanded information at the back of this guide.

How To Contact Us

We know this is a lot of information and you may have questions. We are here to help you! If you can't find what you're looking for by visiting **www.BlueOptionSC.com**, need more information or have any questions related to your Blue Option plan, please contact us.

Billing Department
866-569-5933
8:30 a.m. – 5 p.m.
Monday – Friday

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

Member Services
855-816-7636
8:30 a.m. – 5 p.m.
Monday – Friday

TTY Services
711: 855-816-7636

Store Locations

For your convenience, we have South Carolina BLUE℠ Retail Center locations around the state to help with your health insurance questions. Stop by one of our locations between 9 a.m. – 5:30 p.m., Monday – Friday. Saturdays are by appointment only.

Greenville
1025 Woodruff Road,
Suite A105
Greenville, SC 29607-4113
864-286-2285

Columbia
1260 Bower Parkway,
Suite A4
Columbia, SC 29212
803-264-9000

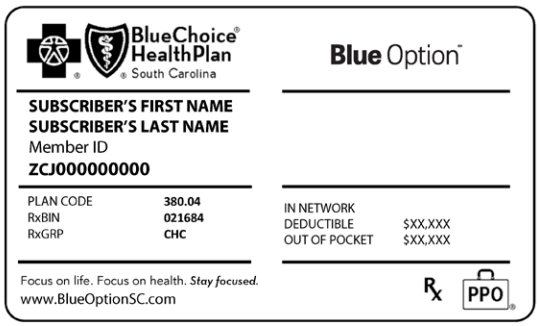
Mount Pleasant
Towne Centre Place
1795 North Highway 17, Unit 7
Mount Pleasant, SC 29464
843-216-7760

Myrtle Beach
Retail Sales Center
3701 Renee Drive
Myrtle Beach, SC 29579
843-736-8811

Important Things To Do

ID Card

Keep your member ID card with you at all times. If you're a new member, you will receive your ID card in a separate mailing. If you have purchased an individual Blue Option plan, you will receive one ID card. If you have purchased a family Blue Option plan, you will receive two cards. The two cards will include the subscriber's name, but all covered family members can use them. 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. Please see your bill for your effective date. Whenever you need medical care, be sure to show your ID card to the health care provider.



Your ID Card Is Digital, Too

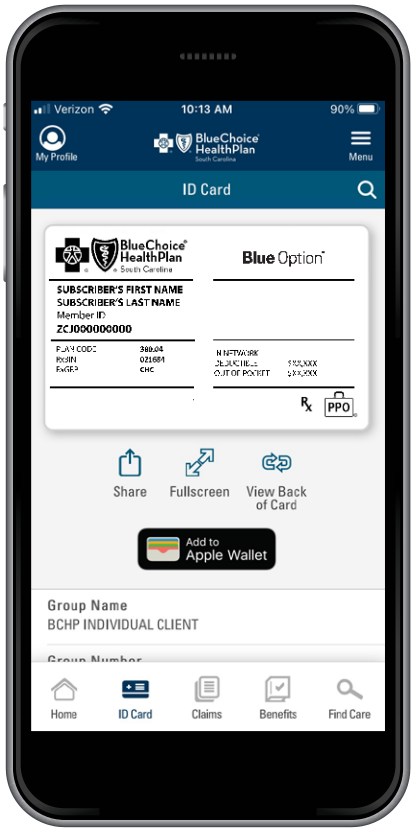
You can access your digital ID card anytime, anywhere from your computer or mobile device.

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 8 for additional information about the My Health Toolkit® app.

You can easily:

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



How To Access Your Digital ID Card

To quickly access your digital ID card, log in to your **My Health Toolkit** account and select **ID Cards** at the top. To learn more about My Health Toolkit and how to log in or create a new account, see page 8.

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

Do You Know All That's Available to You?

With your health plan, you get access to:

- An all-inclusive comprehensive copayment that covers all services at a participating provider's office, such as labs, X-rays, surgical procedures and more! **See page 6**.
  – Ensure laboratories are in network by using the Find Care tool at **www.BlueOptionSC.com.**
  – The copayment does not apply to high-deductible plans.
- Coverage when traveling outside of South Carolina through BlueCard.
- Routine adult and pediatric vision coverage. **See page 11**.
- More rewards with **FOCUS***fwd* **Wellness Incentive Program**. **See page 14**. Look for the running man icon (pictured here) indicating a **FOCUS***fwd* initiative and its Sweepstakes entry values.
- Health management programs to help keep you and your family healthy.
- Virtual visits with a doctor any time day or night for less than $35 on most plans with Blue CareOnDemand Powered by MDLIVE. **See page 9**.
- Doctors Care visits for the same cost as primary care visits, saving you money when an emergency room visit is unnecessary.

for signing up for **FOCUS***fwd*

VISIT TYPE	EXAMPLE OF OUT-OF-POCKET COSTS*
Doctors Care, Primary Care Physician	$50
Blue CareOnDemand	$25
Emergency Room	$500 copayment, then 20% after deductible

- A large network of doctors, hospitals, specialists, pharmacies and other health care providers.
- Preventive screenings at no cost to you.
  For more information, visit **www.HealthCare.gov/Coverage/Preventive-Care-Benefits**.
- $0 cost on covered vaccines, such as flu.
- No claim forms or referrals needed for in-network specialists.
- More lab choices for more savings and less out-of-pocket costs for you.

EXAMPLE	FACILITY FEE*
You use a free-standing ambulatory surgical center.	$200
You use the hospital or an outpatient facility affiliated with a hospital.	Deductible, then 30%

- Partnerships with free-standing imaging centers and ambulatory surgical centers that allow us to pass significant savings on to you.
- A dental allowance for exams and cleanings. **See page 12**.
- Help with services, including financial counseling and planning, college consultation resources, and legal consultations and documents.
- Discounts on fitness memberships, wellness products, cosmetic services and more.
- Convenient online bill payment and online access to plan documents.

*Benefits vary. Please check your Schedule of Benefits.

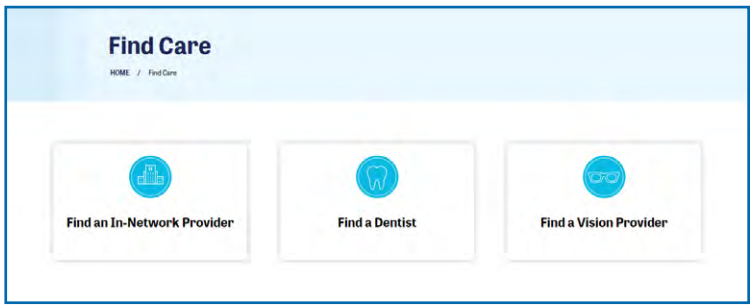
The Blue Option Network

Your network is the Blue Option network. This is an exclusive provider organization (EPO). This means you must get your health care services from providers in this network. Since the majority of providers in the Blue Option network are located in South Carolina, please call the number on the back of your ID card before visiting an out-of-state provider to verify it is in the network. We require all primary care physicians (PCPs) in our network to have 24-hour telephone service and another physician on call if they are unavailable. Blue Option does not provide coverage for out-of-network providers unless the services are (1) due to an emergency medical condition and provided at a hospital or free-standing emergency room or urgent care center; (2) medically necessary air ambulance services; or (3) except where the provider satisfies advance patient notice and consent requirements, either services rendered by an out-of-network provider at certain in-network facilities or specified out-of-network post-stabilization services resulting from an emergency medical condition.

BlueCard Program

When traveling outside of South Carolina, you can locate participating doctors and hospitals nationwide. When you use an in-network doctor or hospital through BlueCard, you receive the highest level of benefits.

Find Care



You can access the full listing of doctors, hospitals and other health providers, including PCPs, in the Blue Option network by visiting **www.BlueOptionSC.com/Find-Care**. You can call, write or email us to request a full directory with this information. You can also get professional qualifications of network providers by calling Member Services. The directory includes professional qualifications of practitioners, such as medical school attended, residency completed and board certification status. If your current doctor is not in the Blue Option network and you are in a treatment plan that began before your effective date, you can use the Transition of Care form.

Continuation of Care

If the network provider's contract with BlueChoice® or Companion Benefit Alternatives (CBA) is modified, 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 if the contract is terminated and you are a continuing care patient of the provider at the time, you may be eligible to continue to receive network benefits for that provider's services for a limited 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 this continued network coverage.

We recommend you use a form for this request. You can find this form on the website at **www.BlueOptionSC.com**. Select **Member Resources**, then **Forms**, or call the Member Service phone number on your BlueChoice ID card. Your treating physician should include a statement confirming you have a serious medical condition. When we get your request, we will confirm the last date the provider is part of our network and 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 under this section, we will provide in-network benefits for you for those services from that provider for the course of treatment relating to your status as a continuing care patient. We will provide benefits for 90 days or until the date you are no longer a continuing care patient with respect to the provider, whichever occurs first. Such continued network status is subject to all other terms and conditions of the policy, including regular benefit limits.

Special Out-of-Network Rules

If you receive treatment from an out-of-network provider as described below, your treatment may be covered under the same terms as if the treatment had been received from an in-network provider, and the allowed amount for purposes of determining your cost sharing liability will be the recognized amount. This exception applies only if one of the situations described below applies. You will still be liable for any in-network cost sharing 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 relating to emergency services furnished at an emergency department visit. In emergency situations, no prior authorization is required. For post-stabilization services, the provider or facility may furnish you a notice of treatment by an out-of-network provider and an opportunity to consent to the treatment in advance, in which case this section will not apply and the post-stabilization services will not be covered by the policy, except for services furnished due to unforeseen, urgent medical needs.
- 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 and your surgeon is in network, but the anesthesiologist is out of network. Except for certain ancillary services, 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 advance, in which case this section will not apply and those services will not be covered by the policy.
- 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 the above has occurred, please contact us using the information on the back of your ID card.

Access the full listing of doctors, hospitals and other health providers, including PCPs, in the Blue Option network by visiting **www.BlueOptionSC.com/Find-Care**.

All-Inclusive Office Visit Copayment

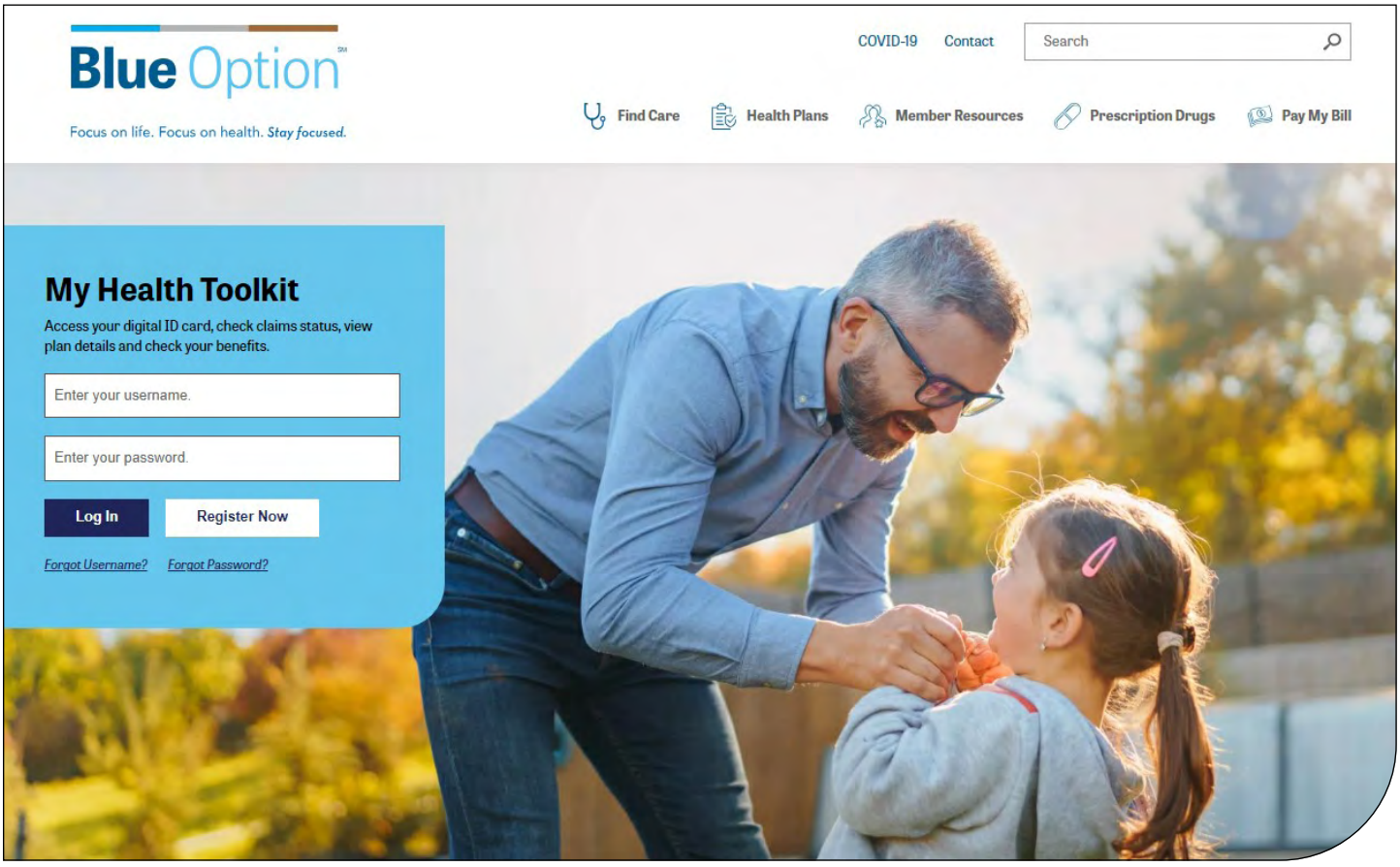
If your plan offers an office copayment benefit, you have the convenience of an all-inclusive, comprehensive copayment. This means that if you visit a network provider, you will pay one copayment for all diagnostic and treatment services performed in the office.

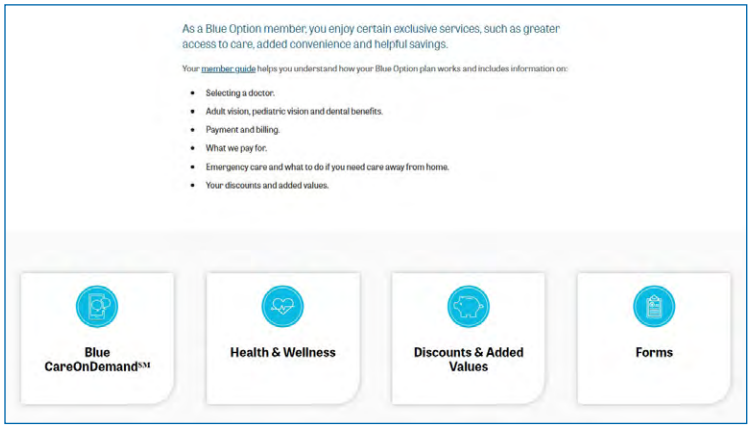
Services are not limited to routine and sick visits. They also include in-office surgical procedures, labs and X-rays with no limits or caps. You can get necessary services at a set cost, with no hidden fees.

Online Resources

When you have questions about your Blue Option plan, visit **www.BlueOptionSC.com** to find the answers. You'll find a wealth of information immediately — on your schedule. Find in-network doctors and hospitals, prescription drug information, and the many discounts and added values you get just for being a Blue Option member! You can also quickly and easily download forms you need in the **Member Resources** section. Once in the Member Resources section, select **Forms**.

We are here to serve you by creating a simpler, more personalized health care experience. That's why we created My Health Toolkit. Visit **My Health Toolkit** at **www.BlueOptionSC.com** to help you manage benefits, treatment and wellness.





Member Resources

My Health Toolkit

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 set your contact preferences by going to **Profile** and selecting **My Account** so you can tell us how you want to receive our communications.

for My Health Toolkit registration

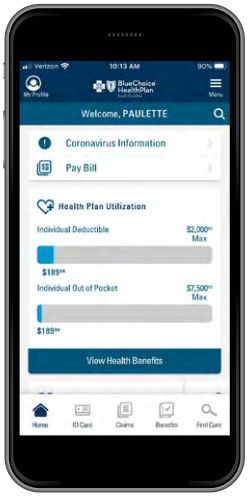
What's Included?

With My Health Toolkit, you can:

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

Download the My Health Toolkit Mobile App Today!

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

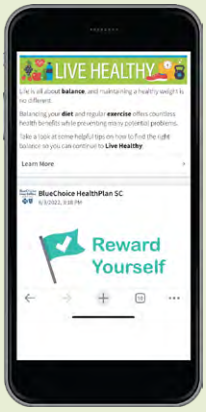


With the app, you can:

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

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

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



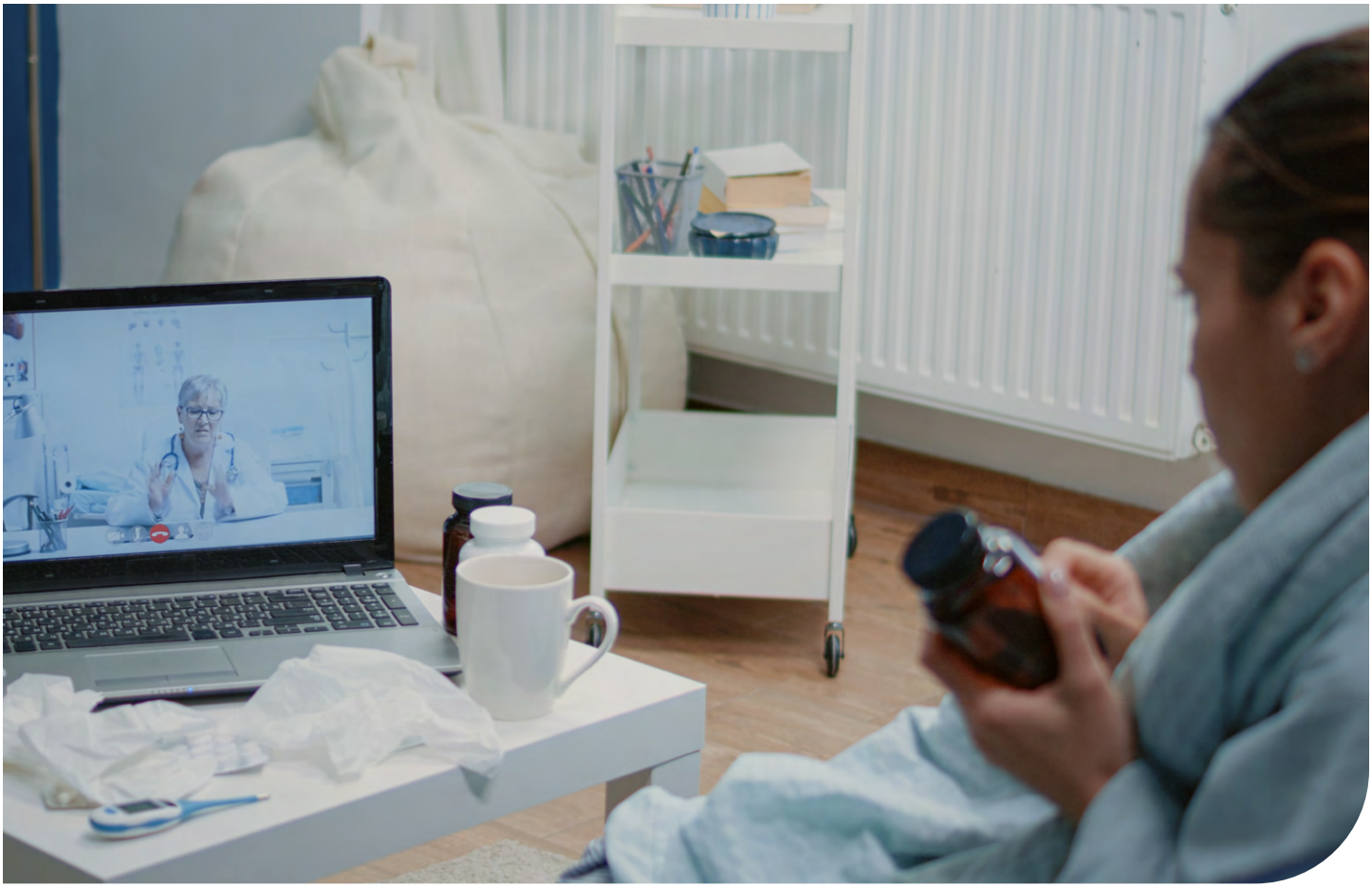
Get Our Texts!

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

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

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

when you sign up to receive text messages



Doctor Visits Anytime, Anywhere for Less Than $35*

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

BLUE CareOnDemand℠
Powered by MDLIVE®

Services Available With Blue CareOnDemand

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

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

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

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

Get Started Now!

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

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

5 entries!

for Blue CareOnDemand registration

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

*Members enrolled in high-deductible health plans must meet any deductible and coinsurance requirements.

Value-Added Benefits and Services

My Life Consult

My Life Consult can help with some of life's biggest challenges. My Life Consult services include these resources and more:

- Financial counseling and planning
- Adult care resources
- College consultation resources
- Legal consultations and documents
- Child care resources
- Parenting/adoption resources
- Individual, couples and family counseling

Members and those in their households receive three life management sessions and three counseling sessions at no cost.

My Life Consult services are offered through First Sun. Because First Sun is a separate company from BlueChoice, First Sun is solely responsible for all services related to individual assistance programs.

Blue365 Discount Programs

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

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

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

*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

**Fitbit and Garmin are independent companies that offer discounts to BlueChoice HealthPlan members.

Vision

All Blue Option plans include routine pediatric and adult vision coverage through an independent company, Physicians Eyecare Network (PEN). PEN provides vision services through the Physicians Eyecare Plan (PEP) on behalf of BlueChoice.

You have access to top retail providers, including Walmart Vision Center, Pearle Vision®, Sam's Club® Optical, LensCrafters®, Target Optical®, JCPenney Optical, Eyeglass World® and America's Best Contacts & Eyeglasses®.

You can also use your material allowance online at **www.PEPOptical.com** to purchase glasses and/or contact lenses and have them shipped free directly to your door. Be sure to use coupon code **BLUEOPTION5** to receive 5 percent off of your purchase.*

*Discount code cannot be combined with other discount codes.

Pediatric Vision Care*

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

- $15 copayment for one annual routine eye exam.
- $49 copayment for one standard contact lens fitting or 15 percent discount off the provider's nonstandard contact lens fitting fee per benefit year.
- $150 material allowance with a $25 copayment every benefit year for glasses and contacts that can be spent on frames, lenses and lens upgrades with no limits on frame or lens selection.
- Discounts of 20 percent on glasses and 15 percent on contacts on any amounts spent over the material allowance at most providers.
- If using an out-of-network provider, up to $40 will be allowed toward the routine eye exam and up to 65 percent of the material allowance that is used, less material copayment. You will need to file your own claim when visiting an out-of-network provider.

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

*For dependent children until 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.

Adult Vision Care

For adults (ages 19 and over), this includes:

- $0 copayment for one annual routine eye exam.
- $49 copayment for one standard contact lens fitting or 15 percent discount off the provider's nonstandard contact lens fitting fee per benefit year.
- $150 material allowance with $0 copayment every benefit year for glasses and contacts that can be spent on frames, lenses and lens upgrades with no limits on frame or lens selection.
- Discounts of 20 percent on glasses and 15 percent on contacts on any amounts spent over the material allowance at most providers.
- If using an out-of-network provider, up to $40 will be allowed toward the routine eye exam and up to 65 percent of the material allowance used, less material copayment. You will need to file your own claim when visiting an out-of-network provider.

Please note that you must visit a provider in the Physicians Eyecare Network (PEN) to receive this benefit. Costs incurred from these services do not count toward MOOP expenses. These benefits are nonessential.*

See the glossary on pages 47 and 48 for a definition of MOOP and other health insurance terms. To locate an in-network eye doctor, please visit **www.BlueOptionSC.com/Find-Care**.

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

Dental Care

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

Adults (ages 20 and over) and children (ages 19 and under) get:

- 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.

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.

Please note: You can visit any South Carolina licensed dentist. Costs incurred from these services do not count toward MOOP expenses.

To locate a dentist, please visit **www.BlueOptionSC.com/Find-Care**.

BlueChoice® HealthPlan
South Carolina

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

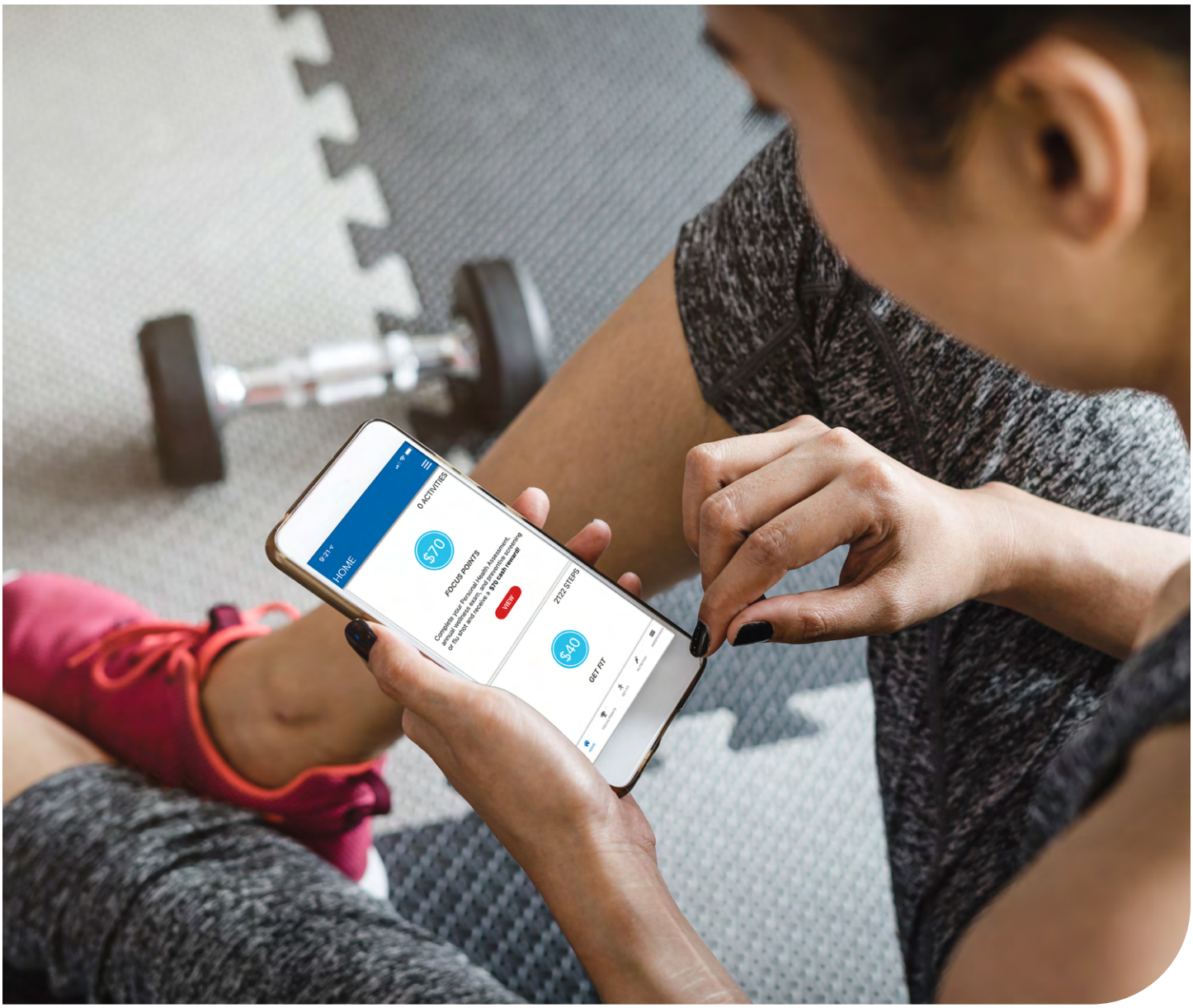
You earn **Sweepstakes** entries for every activity you complete in **FOCUS***fwd*, increasing your chances to win one of the **$1,000 quarterly** and **$5,000 annual cash rewards**. You even earn **10 Sweepstakes entries** by simply signing up for **FOCUS***fwd*!

*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.BlueOptionSC.com**.
2. Log in to **My Health Toolkit**.
3. Access the **FOCUS***fwd* **Wellness Incentive Program** from your My Health Toolkit account 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. Select the **Link FOCUS*fwd* Account** button.
5. You will automatically be directed to the App Store or Google Play.
6. Download the **FOCUS*fwd*** app.
7. Open the app. You're connected!

Download on the App Store

ANDROID APP ON Google play

Get Moving With GET FIT

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

GET FIT Step Challenge

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

Get started:

1. Visit **www.BlueOptionSC.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.BlueOptionSC.com**.
2. Log in to **My Health Toolkit**.
3. Access the **FOCUS***fwd* **Wellness Incentive Program**.
4. Select **GET FIT**.
5. Select the **Connect** button on the compatible device (Fitbit, Garmin or Misfit**). 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.BlueOptionSC.com** on your mobile device.
2. Log in to **My Health Toolkit**.
3. Access the **FOCUS***fwd* **Wellness Incentive Program**.
4. Select the **Learn more** button.
5. Select the **Link FOCUS***fwd* **Account** button.
6. You will automatically be directed to the App Store or Google Play.
7. Download the **FOCUS***fwd* app.
8. Open the app and follow the prompts to connect your device.

Once you link your **FOCUS***fwd* account in the app, you can access **FOCUS***fwd* directly from the app without going through My Health Toolkit. To learn more about device integration, go to **www.BlueOptionSC.com/FOCUSfwd-Device-Integration** 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, Garmin and Misfit are independent companies that provide health and wellness products and services to members of BlueChoice HealthPlan.

Personal Health Assessment

Taking a 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 recommendations based on your responses.
- 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.BlueOptionSC.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. After you complete your PHA, you'll be one step closer to completing our **FOCUS Points*** program. You'll earn **$70 in rewards** when you complete your PHA, annual wellness exam, and preventive screening or flu vaccine. You'll also earn **40 Sweepstakes entries**, increasing your chances of winning one of the **$1,000 quarterly** and **$5,000 annual cash rewards**.

How Can My Spouse Take the PHA?

Your spouse can take the PHA by following the steps above.

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

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

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

for participating in Great Expectations

Members with a complex health condition may be contacted to participate in our Case Management program. For a complete description of these Great Expectations programs, visit **www.BlueOptionSC.com/GreatExpectations**.

How the Programs Work

After enrolling, you will receive information welcoming you to the program. You can connect with your care manager digitally using the My Health Planner app, by phone or through a combination of both.

My Health Novel

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

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

for completing the assessment in My Health Novel

Behavioral Health Resources

We know taking care of your mental health can help improve physical health and all aspects of life. That's why BlueChoice provides a variety of services for members dealing with depression, anxiety and other behavioral health conditions.

With BlueChoice:

- You receive three face-to-face counseling sessions through My Life Consult, provided by First Sun.
- Our Great Expectations *for health* behavioral health programs provide support for members with bipolar disorder, depression, substance use disorder, and stress and anxiety. These programs are offered through CBA. CBA is a separate company that manages behavioral health benefits on behalf of BlueChoice.
- You have access to mental health services anytime, anywhere with Blue CareOnDemand Powered by MDLIVE.
- You have access to behavioral health management mobile apps at no cost through My Health Novel.

My Diabetes Discount Program

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

Program Checklist

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

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

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

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

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

[1]Members under the age of 18 require a fasting glucose test instead of a comprehensive metabolic panel test.
[2]For members under the age of 18, the parent/guardian must meet the diabetes education requirement.
[3]The $0 insulin copayment will be available for one year from the start date of the benefit — for example, April 1, 2024, through March 31, 2025.

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.

Payment and Billing

*Quick*Bill℠ is our secure online payment system. Through *Quick*Bill, you can view and pay your bill 24/7. You'll also be able to set up recurring and scheduled payments.

Visit **www.QuickBillSC.com** to create your account. You will need your member ID number, which is located on your ID card, to create an account and pay online.

You will receive your monthly bill by the 16th of each month, with the premium due by the first of the next month. For example, if you get a bill on April 16, it will be due by May 1.

If you fail to pay your premiums by the end of the grace period, your benefits (prescriptions, doctors visits, etc.) will not be covered and your policy will be canceled.

Please note that you have an age-related policy. This affects anyone on your policy age 15 or older. It means there will be an age-related rate change every year for those members. If you or a member on your policy is age 15 or older in 2023, you will see your rate change starting January 1, 2024, and every January thereafter.

You can pay your bill via our automated phone service. Be sure to have your member ID number ready. Simply call **866-569-5933** and choose option 1. You can also pay your bill through our automated payment kiosks. Kiosks can be found at our Greenville and Columbia South Carolina BLUE Retail Center locations. Please be sure to have your member ID card and billing ZIP code available for payment.

For questions about your bill, please call our billing area at **866-569-5933** Monday through Friday from 8:30 a.m. to 5 p.m.

How Your Plan Works

Understanding your Blue Option plan is one of the best ways to make your coverage work for you. The information in this member guide will help you learn how it works before you need to use it. This is important to make sure you don't have unexpected or unnecessary costs.

What We Pay For

We cover services that are medically necessary and listed as a covered service by your plan. Please note that the amount paid for these services is subject to your specific plan. See your Schedule of Benefits by visiting **www.BlueOptionSC.com** and logging in to My Health Toolkit. We pay for covered services you receive only while you are a member of BlueChoice.

The 10 essential health benefits and services your plan covers are:

1. Ambulatory patient services.
2. Emergency services.
3. Hospitalization.
4. Laboratory services.
5. Maternity care.
6. Mental and behavioral health treatment.
7. Pediatric services.
8. Prescription drugs.
9. Preventive and wellness services.*
10. Rehabilitative and habilitative services.

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

These in-network providers have agreed to:

- File all claims for covered services directly to us.
- Collect copayment, coinsurance and deductible amounts from you. You can find the amounts you pay in your Schedule of Benefits. The meaning of each of these terms can be found in the glossary on pages 47 and 48.
- Accept what we have agreed to pay them as payment in full for covered services minus any coinsurance, copayment or deductible.

*For more information, visit **www.HealthCare.gov/Coverage/Preventive-Care-Benefits**.

What We Do Not Pay For

Please refer to your Member Policy by visiting **www.BlueOptionSC.com/Member-Resources** for a complete list of the services your plan doesn't cover. Services we don't cover are called exclusions. Services with restrictions are called limitations. You will be responsible for payment of noncovered services.

You are responsible for paying the provider's bills when you do not use a Blue Option network provider. No benefits are provided for services received out of network unless the services are (1) due to an emergency medical condition and provided at an urgent care center, hospital or free-standing emergency room; (2) medically necessary air ambulance services; or (3) except where the provider satisfies advance patient notice and consent requirements, services rendered by an out-of-network provider at certain in-network facilities or specified out-of-network post-stabilization services resulting from an emergency medical condition.

Services and Supplies We Don't Cover

We don't provide benefits for these items unless otherwise specified in the Schedule of Benefits. We will not deny treatment of an injury this policy generally covers if the injury results from being a victim of an act of domestic violence.

Excluded Services

Except as specifically provided in this policy, even if medically necessary, no benefits will be provided for:

- Services for which no charge is normally made in the absence of insurance.
- Services, supplies or prescription drugs for which you are entitled to benefits under Medicare or other governmental programs, except Medicaid.
- Injuries or diseases paid by workers' compensation or settlement of a workers' compensation claim.
- Treatment provided in a government hospital for which you are not legally responsible.
- Illness contracted or injury sustained as the result of war or act of war (whether declared or undeclared), participation in a riot or insurrection, or service in the armed forces or an auxiliary unit.
- Treatment, services or supplies received as a result of suicide, attempted suicide or intentionally self-inflicted injuries unless it results from a medical (physical or mental) condition, even if the condition is not diagnosed prior to the injury.
- Any plastic or reconstructive surgery done mainly to improve the appearance or shape of any body part and for which no improvement in physiological or body function is reasonably expected, also known as cosmetic surgery. Cosmetic surgery includes but is not limited to surgery for saggy or extra skin (regardless of reason); any augmentation, reduction, reshaping or injection procedures of any part of the body; rhinoplasty, abdominoplasty, liposuction and other associated types of surgery; and any procedures using an implant that doesn't alter physiologic or body function or isn't incidental to a surgical procedure. Cosmetic surgery does not include reconstructive surgery incidental to or following surgery resulting from trauma, infection or other diseases of the involved part. Complications arising from cosmetic surgery are also not covered.
- Eyeglasses, contact lenses (except after cataract surgery), except as shown in the Covered Services section of the contract, 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) or keratomileusis (laser eye surgery or Lasik), 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.
- Services, care or supplies used to detect and correct, by manual or mechanical means, structural imbalance, distortion or subluxation in your body for the purpose of removing nerve interference and its effects when this interference is the result of or related to distortion, misalignment or subluxation of or in the spinal column.

- Services and supplies related to nonsurgical treatment of the feet, except non-U.S. Food and Drug Administration (FDA)-approved technologies for nonsurgical foot treatment related to diabetes.
- 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. This includes but is not limited to apicoectomy (dental root resection), root canal treatment, alveolectomy (surgery for fitting dentures) and treatment of gum disease. 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.

Other Services This Policy Does Not Cover

- Services, supplies or prescription drugs received from a nonnetwork provider, unless the services are (1) due to an emergency medical condition and received in a hospital, free-standing emergency room or urgent care center; (2) medically necessary air ambulance services; or (3) except where the provider satisfies advance patient notice and consent requirements, services rendered by an out-of-network provider at certain in-network facilities or specified out-of-network post-stabilization services resulting from an emergency medical condition.
- Services, procedures, charges, supplies, equipment or pharmaceuticals for which prior authorization is required and not obtained.
- 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, please review the Member Policy for your Blue Option plan on our website.

If You Need a Prescription

Your plan includes prescription drug coverage. You can quickly find covered drugs by visiting **www.BlueOptionSC.com/Prescription-Drugs**. Prescription drug coverage services are administered by Optum Rx®, an independent company that provides pharmacy benefit management on behalf of our members.

What Is a Covered Drug?

These are drugs we cover under your Blue Option 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 seven coverage levels, called tiers. Please refer to your Schedule of Benefits and the Prescription Drug Formulary to find out how much you will pay for a drug on each of the tiers.

TIER 0	These drugs are considered preventive medications under the Affordable Care Act, and we cover them at no cost to you.
TIER 1	Drugs on this tier are usually preferred generic drugs. They will typically cost the least amount of money out of your pocket.
TIER 2	Drugs on this tier are usually generic drugs. They will typically cost less than brand-name drugs.
TIER 3	Drugs on this tier are usually preferred brand-name drugs. They typically cost less than other brand-name drugs.
TIER 4	Drugs on this tier are usually nonpreferred brand-name drugs. They typically cost more than other brand-name drugs and may have generic equivalents.
TIER 5	Drugs on this tier are usually preferred specialty drugs that are used to treat complex conditions. They are typically very expensive.
TIER 6	Drugs on this tier are usually specialty drugs that are used to treat complex conditions. They are typically the most expensive drugs available.

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 Schedule 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 Optum Rx Home Delivery. 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.

If a drug manufacturer provides any form of direct support (cash, reimbursement, coupon, voucher, debit card, etc.) for some or all of the cost sharing on the purchase of prescription and/or specialty drugs, this amount will not be counted toward the member's annual limitation on cost sharing. The drug will still be considered a covered prescription drug.

Your plan includes additional limits and requirements on some medications.

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 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 the 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.

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 limit or step-therapy requirement, call the Member Services number on the back of your member ID card.

Pharmacy Network

As a Blue Option member, you have a pharmacy network of nearly 55,000 pharmacies nationwide that offers access to a wide variety of pharmacy options, including CVS, Walmart and Kroger locations, plus many other grocers and independent pharmacies.

With the Blue Option pharmacy network, you can also fill prescriptions for up to a 31-day supply at participating pharmacies, offering convenience and potential cost savings. **Note that filling prescriptions at a pharmacy that is not in the Blue Option pharmacy network will require you to pay full price.** This network excludes Walgreens. For more information on your pharmacy benefit, including a list of network pharmacies, visit **www.BlueOptionSC.com**.

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 our specialty pharmacy. If you have a prescription for one of these medications, please call the specialty pharmacy at **877-259-9428**. Specialty drugs are available for a 30-day supply.

Can Drugs That Are Covered Change?

The drug list may change from time to time. Visit **www.BlueOptionSC.com/Prescription-Drugs** and check out the Prescription Drug Tool as well as additional pharmacy information.

What if My Drug Is Not Covered?

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

- Ask Member Services for a list of similar drugs that your plan covers. 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 available at a lower tier may be easier to get and cost you less than drugs on higher tiers.
- You are entitled to request that BlueChoice make an exception and cover your drug. 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 they cause you to have adverse medical effects. There are different types of exception requests:
  - You can ask us to cover your drug, even if it is not on our drug list.
  - You can ask us to remove coverage restrictions or limits for 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.

If you or your physician requests a brand-name drug when a less expensive generic equivalent is available, then you will pay the brand-name drug copayment or coinsurance that applies to your prescription. You will also pay any difference between the cost of the generic option and the brand-name drug. In no instance will you be charged more than the actual retail price of the drug.

For More Information

For more information about Blue Option prescription drug coverage, please log in to your **My Health Toolkit** account and review your Schedule of Benefits.

If You Need Emergency Care

There may be times when you need emergency care. We encourage you to call your PCP before you seek care in an emergency situation. If it is not possible to call your 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 Schedule of Benefits lists the 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 the service is received in network or out of network.

You can find more information about coverage for emergency care in your Schedule of Benefits and Certificate of Coverage. These can both be found when you log in to your My Health Toolkit account. Here are some examples of situations that we do not consider an emergency:

- 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 we consider 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

If You Need Care Away From Home

We will cover initial treatment of emergency brand-name urgent care if you are traveling outside of the Blue Option network service area and need treatment. Please call **800-810-BLUE** (2583) and ask for a referral to the nearest hospital or urgent care center. If you have an emergency, please go the nearest hospital.

If You Need To See a Specialist, Get Behavioral Health Care Services or Be Hospitalized

We encourage you to have a primary care physician (PCP) assist you in managing your health. By having a PCP, if you need assistance he or she can't provide, he or she will help you find an in-network specialist, including a behavioral health practitioner or hospital. If you do not have a PCP, visit **www.BlueOptionSC.com/Find-Care** to find an in-network provider. Please review this information before an emergency occurs so you'll understand your health plan benefits.

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 22.

HIPAA

BlueChoice has always had a commitment to protecting your confidential health information. The Health Insurance Portability and Accountability Act of 1996 (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 your spouse, family member or close friend to contact us for your claims or payment information, we can't release it to them unless you give us permission in writing.

For your convenience, we have created an Authorization To Disclose Protected Health Information form. 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.

If you'd like to complete the form, please use the one on page 33. Please complete all required information and mail it to BlueChoice HealthPlan, Attn: Privacy Officer (AX-400), P.O. Box 6170, Columbia, SC 29260-6170 or fax it to **803-714-6443**.

If you'd like to learn more about how we protect your health information, please review our privacy practices included in this document.

Rights and Responsibilities

At BlueChoice, we are dedicated to being your partner in health care. We want to make sure that you receive the information you need about your health plan, the people providing your care and the services they provide. Knowing this information allows you to be an active participant in your own care. As part of this process, you need to understand your rights and responsibilities as a BlueChoice member, which are as follows:

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 constructively share their opinions, concerns or complaints.
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 to participate in developing a mutually agreed upon treatment plan and to follow the directions agreed on.
7. Members have the responsibility to think about what might happen if they don't follow their doctors' treatment plans or suggestions.
8. Members have the responsibility to keep appointments they schedule. In cases where they may have to cancel or may be running late, members have the responsibility to call the office and let them know.
9. Members have the responsibility to read all our materials carefully as soon as they sign up for BlueChoice. Members have the responsibility to follow the rules of their membership.

Notice of Privacy Policies

You will find the notice of privacy practices on pages 41 through 44. You can also find it by visiting **www.BlueOptionSC.com/privacy-legal**, or you can call Member Services, and we will mail you a copy.

BlueChoice® HealthPlan South Carolina

An independent licensee of the Blue Cross and Blue Shield Association

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO A THIRD PARTY

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

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

   Mailing Address: _____

   Member ID Number: _____

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

   Name: _____

   Mailing Address: _____

   Telephone Number: _____ Relationship: _____

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

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

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

   _____

   _____

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

   ☐ At my request. OR

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

   _____.

5. **Expiration and Revocation.**

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

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

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

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

   Signature: _____ Date: _____

   Personal Representative's Signature: _____ Date: _____

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

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

Policies and Procedures

In this section, you will find information about many of our policies and procedures.

Administering Benefits for Appropriate Services

We are committed to offering you the best benefits. 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 underuse.

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) or by faxing your appeal to 803-714-6463. Your appeal must include:

- Your name and identification number as shown on your member 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. We will notify you of our decision in writing within 30 days if we are giving a denial 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. Please call our Member Services department (see the Welcome page) to find out your specific options for an 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.

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.

Privacy Practices

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

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

Please visit the Privacy & Legal page of **www.BlueOptionSC.com** to view our Notice of Privacy Practices, which covers our policies for use and disclosure of PHI; your right to authorize, restrict or deny the release of PHI; your right to access or request amendment to PHI; and protection of information disclosed to plan sponsors.

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 35, 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.

Subrogation

If you receive medical benefits under this policy for an injury caused by the act or omissions of a liable third party and receive a settlement, judgment or other payment relating to the injury from a liable third party, any other person, firm, corporation, organization or business entity, you agree to reimburse us for not more than the amount that we have paid relating to the injury. This agreement is a condition to receiving benefits under this policy. Our right to subrogation or reimbursement applies to any judgment and/or settlement proceeds, whether or not liability is admitted.

Our interest in subrogation or reimbursement extends to all benefits relating to your injury, even if claims for those benefits have not been submitted to us for payment at the time you receive the settlement, judgment or payment.

You have the right to petition the director of insurance, or his designee, to determine if our subrogation action is inequitable or unjust. If the director makes the determination that allowing subrogation is inequitable or unjust, then it is not allowed. This determination by the director may be appealed to the Administrative Law Judge Division as provided by law. We will pay attorney fees and costs from the amount recovered.

If you choose not to pursue an action to recover damages, you agree to transfer all rights to recover damages in full for such benefits to us. At our expense, we lawfully stand in the place of you to recover the amount of money we have paid for your medical benefits from any third party who is liable, responsible or otherwise makes a payment for your injury. We may seek recovery for its payment of claims from the liable third party, any liability or other insurance covering the liable third party or from your own uninsured motorist insurance and/or underinsured motorist insurance.

In all situations involving subrogation, you shall not do anything to hinder or slow our right to seek reimbursement. You shall cooperate with us, sign any documents and do all things necessary to protect and secure our subrogation and reimbursement rights.

Each time a claim is filed with a diagnosis that could be related to an accident or injury, you may receive a notice stating that we need information to complete processing the claim, along with a questionnaire regarding the claim. For your files to be updated, you must return the questionnaire with the requested information.

If you have any questions, concerns, complaints, compliments or suggestions, please contact Member Services (see page 1).

BlueChoice® HealthPlan
South Carolina

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Privacy Promise

We understand the importance of handling your medical information with care. We are committed to protecting the privacy of your medical information. State and federal laws require us to make sure that your medical information is kept private. Federal law requires that we provide you with this Notice of Privacy Practices, which describes our legal duties and privacy practices with respect to your medical information and your legal rights with respect to our use and disclosure of your medical information. We are required by law to follow the terms of the Notice currently in effect. This Notice is effective September 23, 2013, and will remain in effect until it is changed or replaced.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as the law allows. These changes will be effective for all medical information that we keep, including medical information we created or received before we made the changes. When we make a material change to our privacy practices, we will provide a copy of a new notice (or information about the changes to our privacy practices and how to obtain a new notice) in a mailing to members who are covered under our health plans at that time.

Uses and Disclosures of Medical Information

Treatment, Payment, Health Care Operations
We may use and disclose your medical information for purposes of treatment, payment and health care operations.

Treatment: We may disclose your medical information to a physician or other health care professional to help him or her provide your treatment.

Payment: We may use or disclose your medical information for these and other activities related to payment:

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

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

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

- 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.

BlueChoice® HealthPlan
South Carolina

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)

BlueChoice® HealthPlan South Carolina

Blue Option℠

Change Request Form
BlueChoice HealthPlan Individual Health Coverage

If you would like to make changes, such as correct a phone number or email address, or cancel your entire plan, please fill out this form and send it to us at the address below. If you need an additional Change Request Form, you can find it by visiting www.BlueOptionSC.com and selecting the Forms icon under Member Resources. Please contact Member Services at 855-816-7636 with any questions you may have.

ID Card Number: _____ Phone: _____

Policyholder's Name: _____

Policyholder's Address: _____

City: _____ State: _____ ZIP Code: _____

I want to correct: ☐ Phone Number ☐ Email Address ☐ First and/or Last Name ☐ Address

Phone Number: _____ Email Address: _____

First and/or Last Name: _____

Address: _____

I want to add: ☐ Social Security Number (SSN) SSN To Be Added: _____

I want to remove: Name: _____ Date of Birth: _____ SSN: _____

I want to cancel my plan effective my next due date of: _____/_____/_____.

Premiums are drafted from my account: ☐ Yes ☐ No

Note: All cancellations will be effective at the end of the month in which we receive your request.

Reason for Cancellation: _____

Automatic Draft: ☐ Add ☐ Change ☐ Cancel

(Include a copy of a canceled check from the account you want us to draft. Allow 30 – 45 days for the bank draft setup/changes.)

Credit Card Number: _____ Expiration Date: _____ CVV/CVC: _____

Name on Card *(if different from subscriber)*: _____

Billing Address *(if different from address on file)*: _____

Bank Name: _____ Bank Routing Number: _____

Bank Account Number: _____ Account Holder's Name: _____

Signature: _____

Note: For legal reasons, you must present all changes in writing. The policyholder, or parent/guardian if the policyholder is a minor, must sign, not type, the change request. We will not honor requests without a valid signature.

How to reply: Mail this form along with any necessary documentation to
BlueChoice HealthPlan, Attn: Billing AX-430, P.O. Box 6000, Columbia, SC 29260.
Or you can email this form to BCHPIND@BlueChoiceSC.com.

Glossary

Affordable Care Act (ACA) — The health care reform law. This law was passed in two parts. The Patient Protection and Affordable Care Act became law on March 23, 2010. This law was amended by the Health Care and Education Reconciliation Act on March 30, 2010. Affordable Care Act refers to the final, amended version of the law. Some people also call this law Obamacare.

Allowed Amount — The dollar amount that a health plan determines is appropriate for a covered service. Blue Option network health care providers have agreed to accept the allowed amount as full payment (minus applicable copayments), which means you pay less for your care.

Authorization — The approval of medically necessary care by a managed care or insurance company.

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

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

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.

Covered Service — Medical service that your health plan will pay for. We outline covered services in your Schedule of Benefits or Certificate of Coverage.

Deductible — The amount of medical expenses that the member must pay during a particular period (usually a year) before certain benefits payable by the health plan become effective. For instance, if your health plan has a $200 deductible per 12-month period, you would be responsible for paying $200 worth of covered medical services within 12 successive months before your health plan would begin reimbursing for covered services. Please note that coupons for medical services and/or prescription drugs may not be used to satisfy the deductible when a generic prescription drug is available.

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.

Exclusions — Specific conditions or circumstances the contract does not cover.

In-Network Care — Refers to services you receive from physicians who participate in the Blue Option network.

Maximum Out of Pocket (MOOP) — The MOOP is the most you pay during a policy period (usually one year) before BlueChoice starts to pay 100 percent for covered essential health benefits that are provided by in-network providers. This limit must include deductibles, coinsurance, copayments and/or similar charges. It also includes any other expenditure that is a qualified medical expense for the essential health benefits. This limit does not have to count premiums, balance billing amount for nonnetwork providers, health care your plan doesn't cover, or coupons for medical services and/or prescription drugs when a generic prescription drug is available.

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

Network — The hospitals, physicians and other medical professionals who contract with BlueChoice HealthPlan in the Blue Option network to provide care for you. Also referred to as participating or in-network providers.

Network Provider — Network providers are doctors, hospitals and other health care providers that we have contracted with to provide health care services to our members. Network providers are also called "in-network" providers or "participating" providers.

Nonessential Benefit — Any benefit provided that is not considered an essential health benefit is a nonessential benefit.

Out-of-Pocket Costs — Your costs for health care that your health plan doesn't pay. Depending on your plan, this may include your deductible, coinsurance and copayments for covered services.

Out-of-Network Care — Services you receive from physicians who do not participate in the Blue Option network.

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

Primary Care Physician — Doctors who provide primary care include pediatricians, family medicine doctors and internal medicine doctors. These doctors usually treat the whole person and may provide preventive care and routine checkups, as well as sick care or treatment of chronic illnesses.

Referral — When your doctor sends you to a specialist or health care facility to get certain health care services. Some health plans require you to get this from your PCP.

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

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

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

SCLAHIGA also does not provide coverage for:

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

LIMITS ON AMOUNTS OF COVERAGE

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

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

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。(Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

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

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل 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'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ 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)

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