Blue Option℠
Transparency in Coverage

- **Out-of-network Liability and Balance Billing**
  - Benefits are provided in network only. This policy requires you to use our network providers in the Blue Option Network. No benefits are provided for service received out-of-network unless the service is due to an Emergency Medical Condition. To find a network provider, go to: https://myhealthtoolkit-connect.werally.com/enter-alpha-prefix?lobCode=BCHPX&alpha=ZCJ?
  - Use of the Emergency Room is intended only for persons who are experiencing an Emergency Medical Condition. An Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent lay-person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: 1) placing the health of the individual (or with respect to a pregnant woman, the health of the unborn child) in serious jeopardy; or 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part. We will review requests for benefits after an Emergency Room visit to determine if the illness or injury was sudden or unexpected or would be expected to cause a serious risk to your health, or your unborn child's health, if not treated immediately. Requests for services that do not meet the definition of an Emergency Medical Condition will be denied as not covered.

    Benefits are available to treat an Emergency Medical Condition only when provided on an Outpatient basis at a Hospital Emergency Room or at an Urgent Treatment Center, and only for as long as your condition continues to be considered an Emergency. If you receive care for an Emergency Medical Condition and are treated in the Emergency Room at a Hospital, the charges for Emergency Services are paid as follows:

    1. Emergency Care Benefits – In-Network and Out-of-Network

       A. Benefits are provided for services and supplies for Stabilization and/or initial treatment of an Emergency Medical Condition. If possible, call your Primary Care Physician prior to seeking treatment. If it is not possible to call your Primary Care Physician or delaying medical care would make your condition dangerous, please, go to the nearest Hospital. Your claim for Emergency Services will be reviewed to ensure it meets the definition of an Emergency Medical Condition. If your claim does not meet the definition for an Emergency Medical Condition, benefits will be denied whether the service is provided by an In-Network Provider or not.

If you are admitted to a Hospital due to an Emergency Medical Condition, you or someone acting on your behalf, must contact BlueChoice within 24 hours or the next working day, whichever is later, at 1-800-950-5387. If the Admission occurs outside the Local Service Area or at an out-of-network provider, you may be required to transfer to a Hospital within the Local Service Area once your condition has stabilized in order to receive benefits. If an Admission occurs within 24 hours after an Emergency visit as a result of the Emergency Medical Condition, the Emergency Copayment, if any, will be waived and the applicable Copayment for Admission will be assessed.

In order to be Covered, any follow-up care must be provided by an In-Network Provider.

The Allowed Amount for benefits for Emergency Services for an Emergency Medical Condition when provided by an Out-of-network Provider will be the greater of: 1) the median amount for those Emergency Services, calculated using reimbursement rates of Network Providers who participate in the Blue Option Network; or 2) the amount for those Emergency Services calculated using Medicare reimbursement rates, which is the same method BlueChoice generally uses to determine payment to Out-of-network Providers who do not participate in the Blue Option Network.

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

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

    https://www.blueoptionsc.com/sites/default/files/user_files/documents/member-claim-form_03.pdf

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

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

- **Grace Periods and Claims Pending Policies During the Grace Period**
  - This policy has a grace period for premium payments. This means if your premium is not paid on or before the date it is due, it may be paid during the grace period. If the premium has not been paid by 12:01 a.m. of the day following the end of the grace period, the coverage will automatically terminate without further notice. Any claims paid after the last premium-paid date, do not extend this coverage.
  - "Pending claims" is the withholding of claims payments to the provider or you during a grace period.
  - The grace period is 31 days, during which benefit payments will be pended until all premiums are paid.

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

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

- **Medical Necessity and Prior Authorization Timeframes and Enrollee Responsibilities**

  Prior Authorization must be received for certain categories of benefits. A failure to get prior authorization may result in benefits being denied. We will make our final benefit determination when we process your claims. Even with a service is authorized; we review each to make sure:

  - The patient is a member under the policy at the time the service is provided.
  - The service is a covered service. Policy limitations or exclusions may apply.
  - The service provided was medically necessary as defined by your policy.

  Network providers in South Carolina will be familiar with the requirement to get prior authorization and will get the necessary approvals. If a network provider in South Carolina does not get the prior authorization, it cannot bill you for the penalty.

  The fact that BlueChoice authorizes services or supplies does not guarantee that all charges will be covered.

  You should work with your providers to request and obtain prior authorization in advance of receiving services, except for emergency and urgent care services.

- **Drug Exceptions Timeframes and Enrollee Responsibilities**
  - The Covered Drug List is the list of drugs covered under Blue Option health plans. When necessary, you may request an exception to have a drug covered that is not on this list.
  - **Formulary Exception Request (standard or expedited):** To request and gain access to clinically appropriate drugs not otherwise covered by the health plan, you may contact our Pharmacy Benefit Manager (PBM). Our Pharmacy Benefit Manager will work with the prescribing physician to obtain any medical records or other necessary information to process the request. We must act on a standard request within 72 hours and on an expedited request within 24 hours after we receive your request for a formulary exception. Expedited requests are available only when you have exigent circumstances: a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a non-formulary drug.
  - For a standard formulary exception, we will notify you no later than 72 hours following receipt of the request, and if approved, will provide coverage of the approved non-formulary drug for the duration of the prescription, including refills. For an expedited formulary exception, the determination will be made no later than 24 hours following receipt of the request and, if approved, will provide coverage of the non-formulary drug only for the duration of the exigent circumstances.
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- If your formulary exception request is denied, you can ask for an exception review. The request can be made by you or your prescribing provider. You can ask for an exception review by contacting us to begin the process at:

  OptumRx
  Prior Authorization Department
  P.O. Box 25183
  Santa Ana, CA 92799
  Fax: 1-844-403-1029

- **Information on Explanation of Benefits**
  - Individual Explanation of Benefits (EOB)

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

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

  - Summary EOB

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

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

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

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

- **Coordination of Benefits**

  Medicare Coverage
  If you are enrolled in another insurance coverage, such as Medicare, that offers medical coverage for any of the benefits under this Policy, BlueChoice may reduce benefits under this Policy to avoid paying benefits between the two plans that are greater than the cost of the health care service. If you and/or your Dependents become eligible for Medicare, you should apply and enroll in Medicare Part A and B, and use Providers who accept Medicare in order to ensure that you receive full benefit coverage. Based on Medicare Secondary Payor legislation, regulations and Centers for Medicare & Medicaid Services guidance, BlueChoice assumes you will enroll in Medicare once you are eligible, and BlueChoice may take into account the benefits that you or your Dependent are eligible for under Medicare, regardless of whether you have actually enrolled for that coverage. In other words, even if you have not enrolled in Medicare, BlueChoice may reduce your claim by the benefits that you are eligible for under Medicare, and then pay the remaining claim amount under the terms of this Policy and in accordance with Medicare coordination rules. As a result, your Maximum out-of-pocket costs may be higher if you do not enroll in Medicare.

  The coordination of benefits (COB) process ensures that claims are paid correctly by identifying the health benefits available to a Medicare beneficiary, coordinating the payment process, and ensuring that the primary payer (Medicare) pays first. It also ensures that the amount paid by plans in dual coverage situations does not exceed 100% of the total claim, to avoid duplicate payment. Even if you have not enrolled in Medicare Part B, we will coordinate benefits and reduce your claim(s) by the benefits that you would be eligible for under Medicare Part B. This may result in physicians billing you for services that were only partially covered under your Blue Option plan.

  Other Valid Coverage: Proration
  This Policy is not meant to duplicate other valid coverage you have with insurance policies; see the Medicare Coverage Provision above.

  If you have other valid coverage and BlueChoice has not been notified of this coverage by you in writing, we will “prorate” benefit payments when your claim is received. We will carefully consider all of the valid health insurance that covers your claims. Then, we will determine its responsibility for your loss in proportion to the responsibility that should be accepted by other insurance companies. We will pay the portion of your claim for which it is responsible.

  If your claim is prorated, you will receive a refund of the portion of the Premiums you have paid for coverage that we did not accept as its responsibility. This refund will be based on Premiums paid during the time both policies were in effect.