Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

Healthy Blue
Evidence of Coverage (EOC)

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BlueChoice HealthPlan is an independent licensee of the Blue Cross Blue and Shield Association. BlueChoice HealthPlan has contracted with Amerigroup Partnership Plan, LLC, an independent company, for services to support administration of Healthy Connections.

Healthy Blue

Table of Contents

Evidence of Coverage

This book is your Evidence of Coverage (EOC). It's a member handbook that tells you how Healthy Blue works. It also tells you which services are covered and which services are not covered. You have the right to request a printed copy of your EOC and/or the provider directory every year at no charge. You can request these materials by calling the Customer Care Center number listed below.

For questions about anything you read in this book
Call the Healthy Blue Customer Care Center (CCC) toll free at **866-781-5094 (TTY 866-773-9634)**, Monday through Friday from 8 a.m. to 6 p.m. Eastern time.

You also can send a secure email to the CCC using our secure member portal. To register for the online member portal:

- Go to **HealthyBlueSC.com**.
- Select **Login** and **Register now**.

TTY lines are for members with hearing or speech loss only.

Healthy Blue

Welcome to Healthy Blue

Dear Member,

Welcome to the Family of Blue℠! We are here to help you stay on top of your health care. In this booklet, you will find:

- Your **Evidence of Coverage (EOC)** — This is all the information you need to make the most out of your benefits. Your EOC tells you about:
  - Your regular Medicaid benefits and services, plus the benefits beyond what you expect from us — see a list on the next page.
  - How to receive your benefits.
  - How to find a doctor in your plan.
  - When to use an urgent care center or the emergency room.
  - When you may need our approval (prior authorization) before receiving a medical service.
  - Your rights and responsibilities as a Healthy Blue member.
  - And more.
- A **Notice of Privacy Practices** telling you how we protect your personal information.

Start using your benefits

- **Look for your ID card in the mail.** We mailed your member ID card separately. It has the name and phone number of your primary care provider (PCP) on the front.
- **Call your PCP's office** to let them know you are a Healthy Blue member. Your PCP will:
  - Learn about you and your health needs.
  - Help coordinate your health care, like sending you to a specialist if needed.
  - Be your first choice for care, other than an emergency. If you have a true health care emergency, go to the nearest emergency room (ER) for care. If you need care right away that is not for an emergency, go to the nearest urgent care center.
- **If you want to change your PCP**, you can pick one from our provider directory — which is a list of the doctors in your plan. You can:
  - Search our online provider directory — Use the **Find a Doctor** tool at **HealthyBlueSC.com**.
  - Receive a printed version — Download it from the *Find a Doctor* page, or call our Customer Care Center (CCC) and ask for a printed copy. It's free.

  Once you find the PCP you want, call our CCC number at the bottom of this page, and we will make the change for you. We will send you a new ID card with your new PCP's name and phone number. Members may also change their PCP through the online member portal at **HealthyBlueSC.com**.

If you have questions, call our CCC Monday through Friday from 8 a.m. to 6 p.m. We are here to help.

Sincerely,

The Healthy Blue team

Customer Care Center (CCC): 866-781-5094 (TTY 866-773-9634) Mon.–Fri. 8 a.m.–6 p.m.
24-Hour Nurseline: 866-577-9710 (TTY 800-368-4424) 24 hours a day, seven days a week

Healthy Blue

Extra benefits

When you are part of the Family of Blue℠, you receive all your regular Medicaid benefits and services through the State, plus extra benefits just for being our member:

- **Free Adult Vision** for members ages 21 and up every two years
- **Free GED Ready Assessment Exam** for members ages 17 and up
- **No copays** for preventive and urgent care visits for members ages 21 and up
- **No referrals needed** to see specialists in your plan
- **Free Girl Scout membership** plus discounts toward program materials for eligible members ages 5–13
- **Free Youth Explorer program** through Boy Scouts of America for members ages 8–18
- **Free smartphone** with monthly minutes, data and text messages
- **Healthy Blue Community Resource Link** to find resources in your community by ZIP code
- **Discounts on Boys & Girls Club fees** for eligible members ages 6–18 at participating clubs
- **Books for Babies℠**— members are able to request a $35 Barnes & Noble gift card that can be used to purchase their choice of books for their baby age 2 years and younger
- **Free MedSync program** to help you get your prescriptions on the same day, each month
- **Free Internet access for two months** in participating areas
- **Free sports physical** for members ages 6–18
- **Free coupon booklet** with discounts to local retailers
- **Free headset learning gear** for members ages 5–18
- **Low-cost or free over-the-counter (OTC) medicines** with a prescription
- **Free flu shots**
- **Free Condition Care program** for members with long-term health issues
- **Discounts for Jenny Craig®**
- **Community events** with food, games and prizes
- **Healthy Rewards gift cards** to use at your favorite retail stores for completing wellness visits and preventive screenings
- **Uber gift cards or annual oil change for members over 18 in case management**
- **Fresh fruits and veggies for two months for members diagnosed with diabetes**
- **Free food delivery** for postpartum parents in case management
- **Tutoring** — eligible members ages 5–14 will receive a $50 voucher that can be used to purchase educational support courses from **outschool.com**
- Learn to Live app for online therapy and support
- Asthma toolkit for qualifying members
- Members who complete focus groups earn rewards, like gift cards
- **Pregnant members and new parents can receive:**

- **Free car seat** for your new baby by going to prenatal visits — member must go to a combination of eight prenatal or postnatal visits
- **Sam's Club membership** to help support healthy parents and babies — member must go to a combination of eight prenatal or postnatal visits
- **Free case of diapers** for members under 15 months of age. Members receive one case of diapers after completing the baby's first well-child visit and can earn a second case of diapers after completing a sixth well-child visit in the baby's first 15 months of life
- **Healthy Rewards gift cards** to use at certain retail stores for going to prenatal, postpartum and well-child checkups
- **Free electric breast pump** for breastfeeding members
- **Free prenatal program** with pharmacy and nutritional counseling
- **Free referrals** for in-home nurse care before and after your baby is born

To learn more about our community events and benefits, log into your member portal at **HealthyBlueSC.com** or call our CCC number at the bottom of this page.

Important information to keep in mind

How to use this book

We made this book easy to use by breaking it into parts. You may read any part at any time. To save you time, we suggest you read some parts before others.

Read these parts first:

- Important things to do
- How to use your health plan
- Emergency and urgent care
- Benefit quick reference guide

Then take some time and read:

- What Healthy Blue covers
- What Healthy Blue and regular Medicaid do not cover
- Programs to help keep you well
- Other things you may need to know
- Your health care rights and responsibilities
- Important phone numbers

Picture in this book

This symbol tells you when you need an approval from Healthy Blue or your PCP before you get care.

To contact us

Call our Customer Care Center (CCC) at **866-781-5094 (TTY 866-773-9634)** Monday through Friday, 8 a.m. to 6 p.m. Eastern time. The phone number is also listed at the bottom of every page.

To send a secure message to the CCC, just log in to the secure member portal at **HealthyBlueSC.com**.

Here's our address:

Healthy Blue
P.O. Box 100124
Columbia, SC 29202-3124

You also can send us a fax at 912-233-4010.

If you are moving

If you move anywhere in South Carolina, we can still be your health plan. When you move, please remember to call Healthy Connections at **888-549-0820 (TTY 888-842-3620)** and tell them your new address. Don't forget to also call the CCC and give us your new address so we can keep sending you newsletters and updates about your plan.

You must call us before receiving any services in your new area unless it is an emergency. You will still receive care through Healthy Blue until your address is updated, unless you have moved out of our service area. Our service area includes every county statewide in South Carolina.

If there are other changes that affect your health care, call us.

Call us if you have any changes to your health insurance coverage — for example, if you have other health insurance through another health plan. You should also call if you have changes in your:

- Living arrangements.
- Family size.

Always call Healthy Connections when there's a change at **888-549-0820 (TTY 888-842-3620)**.

If you have an accident

If you've had an accident at work or been in a car accident, call us. You must notify Healthy Blue immediately of a:

- Workers' compensation claim.
- Pending personal injury lawsuit.
- Medical malpractice lawsuit.
- Car accident involving you.

If you have questions or comments

If you have any questions, please call our CCC number at the bottom of this page.

Call us for more information about:

- Names, addresses, and phone numbers for primary care providers (PCPs), specialists, and hospitals in your area.
- Languages (other than English) spoken by our providers.
- Providers who are taking new patients.
- Any limits on your choice of providers.
- Your rights and responsibilities as a member of our health plan.
- Steps to take for filing grievances, appeals and State Fair Hearings.
- Your health plan benefits.
- How to understand your benefits.
- Any limits on your benefits.

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- How to receive an approval for certain care.
- How to receive benefits for family planning care and supplies from doctors or clinics not in your network.
- Details on family planning care and supplies that you cannot receive with this health plan.
- How to receive specialty care, referrals and other benefits not given by your PCP.
- What to expect if you have an emergency and how to handle the medical care afterward.
- How to receive this book in another format, such as audio file or large print, at no charge to you.

If you call after hours and have a question that is not urgent, leave a message with our answering service. We will call you back the next business day. You can also call 24-Hour Nurseline toll free at **866-577-9710 (TTY 800-368-4424)** 24 hours a day, seven days a week.

Part 1: Important things to do

When you first become a member of Healthy Blue, there are some important things you need to do. You should:

- **Keep your South Carolina Healthy Connections and Healthy Blue ID cards with you at all times.** You will need to show them each time you receive health care services. Do not let anyone else use your ID cards.

- **Make sure the primary care provider (PCP) on your Healthy Blue ID card is the one you want**. Your PCP will be your main doctor. They will give you an approval for treatment if you need one. If you want a different PCP, let us know right away by calling the Customer Care Center (CCC) or through the online member portal at **HealthyBlueSC.com**.

- **Set up your first health exam with your PCP right away.** All new Healthy Blue members should see their PCP within 90 days of joining. The first meeting with your new PCP is important. Your PCP will:
  - Learn about you and talk about your health.
  - Help you understand your medical needs.
  - Tell you how you can improve or maintain your health.

  Call your PCP's office to set up your first doctor visit today.

- **Call your PCP before you receive medical care, unless it's an emergency.** You should always call your PCP first if you need nonemergency care. The staff in your PCP's office will help you set up a doctor visit for care.

- **If it is an emergency, seek help right away**. **Call 911 (or your local emergency phone number), or go to the nearest emergency room (ER) for medical care**. You do not need an approval from us or your PCP for emergency care. It doesn't matter if you are inside or outside of our service area. You are covered for emergency services in the United States, even if the provider is not a part of our network. Healthy Blue's service area is in every county statewide in South Carolina.

An emergency situation is when you have severe, sudden signs of pain and the risk of not receiving medical care right away may:

- Place your health or the health of an unborn child at risk.
- Impair a body function.
- Cause dysfunction of a body part or organ.

For more information on emergencies, please see **Part 9: Emergency and urgent care**.

If you are not sure what to do, you can call 24-Hour Nurseline toll free at **866-577-9710 (TTY 800-368-4424)**. Have your Healthy Blue ID card ready when you call. The nurse will ask for your member ID number.

Part 2: Important phone numbers

Customer Care Center (CCC) ..... 866-781-5094 (TTY 866-773-9634)

Call this number if you want to know more about your Healthy Blue health plan. You also can call this number if you need an interpreter.

24-Hour Nurseline ..... 866-577-9710 (TTY 800-368-4424)

Call this number to talk privately with a nurse. You can call this toll-free line 24 hours a day, seven days a week. You can also call this number for an interpreter.

Pharmacy Member Services ..... 833-207-3118 (TTY 711)

Call this number to get pharmacy member services support to help you whenever you need it. We are here 24 hours a day, seven days a week.

Behavioral Health/Substance Use Services 866-781-5094

Call this number if you want to know how to receive inpatient, outpatient, and other behavioral health services.

Vision Service Plan (VSP) Customer Service ..... 800-877-7195 (TTY 800-428-4833)

Call this number for information on available vision services. Healthy Blue offers vision benefits through Vision Service Plan (VSP). VSP is an independent company that provides vision benefits on behalf of Healthy Blue.

DentaQuest Customer Service 888-307-6552

Call this number for information on available dental services for members under 21 years of age. DentaQuest is an independent company that provides dental benefits on behalf of Healthy Blue.

National Poison Control Center 800-222-1222

Call this number to talk with a nurse or doctor and receive free poison control advice and treatment. You can call this toll-free number 24 hours a day, seven days a week. Calls are sent to the closest local office.

Relay South Carolina ..... 800-735-8583 or 711

Members with hearing or speech loss can call this number to work with a trained person who can help them speak to non-TTY users.

Healthy Connections ..... 888-549-0820 (TTY 888-842-3620)

Call this number if you:

- Move.
- Have changes to your health insurance.
- Want to know what Medicaid doesn't cover.

Call Healthy Connections Choices at **877-552-4642 (TTY 877-552-4670)** to find out more about Healthy Blue services. **TTY lines are only for members with hearing and speech loss.**

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Part 3: The online member portal

We are always looking for tools and technology to make it easier to access care and services. Our online member portal is designed to help you receive the information you need, whenever you need it. When you create a profile at **HealthyBlueSC.com**, you will be able to view your coverage and benefits, access your health information, and receive tips on managing your lifestyle at any time — day or night.

Our online member portal can also help you:

- Request a new ID card.
- Send a secure email to the Customer Care Center (CCC).
- View your Medicaid ID and group numbers.
- Change your PCP.
- Use WebMD tools to:
  - Check your overall health with a health assessment.
  - Keep track of your health records.
  - Look up conditions, general health, and more.
- View drug lists, interactions, and alerts.
- Request pharmacy formulary exceptions.
- And more.

To create a profile, go to **HealthyBlueSC.com** and choose **Login** and **Register Now**. You will be asked to give us some information, like your member ID number, name, and date of birth. Once you do, you will create a username and password to use each time you log in to the portal.

If you have any questions, call the CCC number at the bottom of this page.

Part 4: Benefit quick reference guide

We have made a benefit quick reference guide so you can easily see your Healthy Blue benefits. Some of these benefits have copays, so we have explained those too. Please refer to **Part 6: What Healthy Blue covers** for a full list of your plan's benefits. To get these benefits, the care must be medically necessary.

Medically necessary services are the services covered by the State Medicaid program, including their treatment limits.

Copays

A copay is the amount of money you need to pay to receive a service. Some members will pay low copays for some care. If you cannot pay the copay at the time you receive care, you will still receive the health care you need. Though, you may have to pay the copay later. It will be up to your doctor or other provider to collect the full copay.

These members do not have copays:

- Children under 19 years of age
- Pregnant people
- Members in institutions, like nursing facilities or intermediate care facilities for individuals with intellectual disabilities
- Members getting emergency care in the emergency room (ER)
- Members getting Medicaid hospice benefits
- Members of federally recognized American Indian tribes do not pay most copays. Tribal members do not pay for services from the Catawba Service Unit in Rock Hill, South Carolina, or when referred to a specialist or other medical provider by the Catawba Service Unit.

All other members have these copays:

- Doctor's office, primary care provider (PCP) and specialist visits — $3.30
- Chiropractor — $1.15
- Dental services — $3.40 copay, unless it's an emergency
- Medical equipment and supplies — $3.40 per item
- Home health visits — $3.30 per visit
- Generic or brand-name drugs your doctor prescribes — $3.40 per drug
- Inpatient care given during hospital stay — $25
- Outpatient care given at a hospital, other than ER visits — $3.40
- Podiatrist (foot doctor) — $1.15
- Ambulatory Surgical Center — $3.30
- Federally Qualified Health Centers (FQHCs) — $3.30
- Rural Health Clinics (RHCs) — $3.30

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Members do not have copays for these services:

- Orthotic services provided by and medical equipment and supplies given by the Department of Health and Environmental Control (DHEC)
- Family planning care, supplies or medicine
- End-stage renal disease care
- Infusion center care
- Preventive care or urgent care visits
- Rehabilitative behavioral health services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/well-child visits or services
- Help quitting smoking with:
  - Drugs prescribed by a Medicaid provider
  - Counseling through the Tobacco Quitline at **800-QUIT-NOW (800-784-8669)** or in individual and group settings
- Certain diabetic medications
- Certain cholesterol medications
- Certain blood pressure medications
- Certain contraceptives
- Certain heart and arrhythmic medications
- Certain medications for smoking cessation
- Certain vaccines
- Certain HIV medications
- Naloxone for opioid overdose
- Hospice benefits
- Waiver services
- Emergency room visits in the U.S.*

* Disclaimer: Visits that are considered nonemergencies that are serviced in the emergency room do have a copay.

Benefit quick reference guide

Benefit	Coverage	Limits
Audiological services 	• Hearing exams • Screenings • Preventive and corrective services • Ear molds • Hearing aids and supplies	Only for children under 21 years of age
Behavioral health/ Substance use  $25 copay for inpatient hospitalization. Please see the first page of Part 4 for exclusions.	Inpatient services: • Behavioral health and substance use services at contracted facilities Outpatient services: • Psychiatric diagnostic interview exams • Group, family and individual psychotherapy • Psychological tests • Rehabilitative behavioral health services Substance use services: • Social detoxification • Residential • Partial hospitalization • Intensive outpatient program • Medication assisted treatment services • Psychiatric diagnostic interview exams • Group, family and individual psychotherapy • Psychological tests • Peer and family support • Rehabilitative behavioral health services • Psychological rehabilitative services • Help quitting smoking, including: – Bupropion for tobacco use – Varenicline – Nicotine gum, lozenge, nasal spray, inhaler and patch – One-on-one telephone and web-based counseling through the Tobacco Quitline at **800-QUIT-NOW (800-784-8669)**	We limit: • Psychiatric assessments to one per member per provider every six months. We may approve more reviews when medically necessary. • Individual and group counseling for help quitting smoking to four sessions per quit attempt and two quit attempts per year.

Benefit	Coverage	Limits
	– Counseling in individual and group settings	
Chiropractic services $1.15 copay. Please see the first page of Part 4 for exclusions.	Using the hands to put the bones of the spine back in line	Limited to six visits per benefit year
Chronic renal disease	• Hemodialysis • Peritoneal dialysis • Other dialysis procedures	
Communicable disease services	• Exams and reviews • Teaching you about health topics • Counseling • Contact tracing • Certain outreach for direct observation therapy (DOT) for tuberculosis (TB)	
Dental services $3.40 copay, unless it's an emergency. Please see the first page of Part 4 for exclusions.	Healthy Connections offers routine dental services through DentaQuest. Members under 21 years can receive: • Routine dental care • Oral exams • Cleanings • X-rays • Fluoride treatments ○ Diagnostic, preventive, restorative and surgical benefits Members 21 and older can receive up to $750 each year to use for covered dental services like: • Oral exams • Cleanings • X-rays • Extractions • Fillings • Medically necessary procedures Healthy Blue gives you: • Anesthesia for emergency dental procedures while in the hospital	

Benefit	Coverage	Limits
	• Emergency outpatient dental services Children can receive preventive dental assessments through the month of their 21st birthdays.	
Developmental evaluation services	Healthy Connections covers these services. • Neurodevelopmental assessments • Neurodevelopmental reassessments • Psychological evaluations • Psychological re-evaluations • Pediatric day treatment	Only for eligible members under 21 years of age. We limit: • Neurodevelopmental assessments to 12 units per year • Neurodevelopmental reassessments to four units per visit • Psychological evaluations to 12 units per year and one per six months

Durable medical equipment (DME) and disposable supplies
 	
$3.40 copay per item.
Please see the first page of Part 4 for exclusions.
 	
All custom-made DME needs an approval.
Some other DME needs an approval from Healthy Blue.
 	
Insulin pumps for members with type 1 diabetes require a prior authorization.
	Medically necessary equipment and supplies, including:
	• Medical products and office-based injectables
	• Surgical supplies
	• Wheelchairs
	• Traction equipment
	• Walkers
	• Canes
	• Crutches
	• Ventilators
	• Prosthetic devices
	• Orthotic devices
	• Oxygen
	• Hearing aids and accessories
	• Diabetes supplies, including:
	  • Insulin pumps for members with type 2 diabetes
	  • Insulin pumps for members with type 1 diabetes
	  • Incontinence supplies
		We do not cover:
		• Wheelchair accessories, including but not limited to:
		  - Pillows
		  - Umbrella holders
		  - Crutch and cane holders
		
		Hearing aids and accessories are only for children under 21 years of age.
		
		There are quantity limits for diabetes supplies.

Benefit	Coverage	Limits
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) well-child visits/services	Preventive health care services, including: • Health screenings • Comprehensive health and development history • Developmental assessment • Comprehensive unclothed physical exam • Appropriate immunizations (shots) • Dental assessment • Vision screening • Hearing screening • Anemia screening • Blood pressure • Lead toxicity screening • Lab tests	The EPSDT or well-child program provides comprehensive and preventive health services to children through the month of their 21st birthdays.
Emergency services	We cover all emergency services received in the U.S. You do not need an approval from us for any of these services.	We do not cover emergency services received outside the U.S.
Emergency transportation	Emergency transport given by: • Ambulance • Air ambulance	
Family planning services and supplies	• Medical visits for birth control • Teaching you about family planning • Health education and counseling • Birth control • Pregnancy tests • Lab tests • Tests for sexually transmitted infections (STIs) • Sterilization	We do not cover: • Surgery to reverse sterilization • Hysterectomy for sterilization reasons • Fertility treatments, such as: – Artificial insemination – In vitro fertilization

Benefit	Coverage	Limits
Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services $3.30 copay. Please see the first page of Part 4 for exclusions.	• Preventive care • Primary care • Communicable disease services to help control and prevent disease	
Home delivery pharmacy	You can have your medications shipped right to your home. This can be important for members who live in rural areas or have difficulty leaving their homes. Using this option doesn't mean you aren't able to use a local pharmacy. It's just another way to make sure you can receive the medications you need. All maintenance medications are covered for a 31-day supply. Ninety (90)-day supplies are allowed for certain oral diabetic, cholesterol, asthma, and high blood pressure medications.	
Home health services  $3.30 copay per visit. Please see the first page of Part 4 for exclusions.	• Skilled nursing visits that take place from time to time • Home health aides • Medical supplies and equipment fit for use in the home • Physical, occupational and speech therapy • Supplies a doctor orders	• We do not cover personal care services. • We cover only 50 home health visits per benefit year.
Hospital inpatient services  $25 copay. Please see the first page of Part 4 for exclusions.	• A semiprivate room • Maternity services • Special treatment rooms • Operating rooms • Supplies • Medical tests and X-rays • Drugs the hospital gives you during your stay • Giving you someone else's blood • Radiation therapy	We do not cover private rooms unless medically necessary.

Benefit	Coverage	Limits
	• Chemotherapy • Dialysis treatment • Meals and special diets • General nursing services • Anesthesia • Anesthesia for dental procedures when it is an emergency • Setting up a plan for when you leave the hospital, including future care if you need it • Rehabilitation (rehab) in the hospital • Surgery to repair the breast after a complete or partial removal for any medical reason	
Hospital outpatient services  $3.40 copay for members 19 years of age and older who receive nonemergency services in the emergency room (ER). Members have a $3.30 copay for services in an Ambulatory Surgery Clinic. Please see the first page of Part 4 for exclusions. Physical, occupational, or speech therapy services received beyond the benefit maximum require medical review and prior authorization.	• Care to prevent illness • Care to find out what is wrong with you • Care to treat your health issue • Rehab • Surgical care • Emergency care including outpatient emergency dental services • Renal disease treatment • Neurodevelopmental or mental developmental assessment and testing • Physical, occupational or speech therapy • Family planning • Dialysis • ER use • Drugs a doctor orders • Giving you someone else's blood • Services to prevent problems or find out what is wrong with you • Surgery that does not end in a hospital stay • Sterilization	Neurodevelopmental or mental developmental assessments and testing are only for eligible members under 21 years of age. We limit physical, occupational or speech therapy based on age. • Members 21 years of age and older have a limit of 75 combined visits or 300 units per benefit year. • Members under 21 years of age are limited to 105 combined visits or 420 units per benefit year. • For qualified BabyNet members, services for physical, occupational, and speech therapies are covered through the Individualized Family Service Plan (IFSP).

Benefit	Coverage	Limits
Hysterectomies and abortion services	• Hysterectomies that are: – Nonelective – Medically necessary • Abortions and related services needed to: – Save the life of the mother – End pregnancy resulting from rape or incest	We only cover abortion services when there are complete medical records showing the need for the abortion.
Institutional long-term care and nursing homes	We cover nursing home and rehab services at the skilled, intermediate, or subacute level of care.	• We cover care for 90 continuous days when you are approved for and admitted to a long-term care facility. • Healthy Connections will cover your care after the first 90 consecutive days. They will disenroll you from Healthy Blue as soon as they are able, and you will receive regular Medicaid.
Lab and X-ray services OK Some X-ray services may need an approval from your PCP.	Lab and X-ray services your provider orders.	Services must be medically necessary and ordered by a licensed provider.
Nonemergency transportation OK We need to approve transport to out-of-state medical referrals.	• Nonemergency transfer from a hospital to another hospital, facility or your home • Transport to an out-of-state medical referral	
Outpatient Pediatric AIDS Clinic Services (OPAC)	Services for HIV-related and exposed Healthy Blue children and their families, including: • Specialty care • Consults	

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Benefit	Coverage	Limits
	• Counseling • Clinical and lab tests	
Pharmacy and over-the-counter products  $3.40 copay for members 19 years of age and older for generic or brand-name prescription drugs. Please see the first page of Part 4 for exclusions.	See the Preferred Drug List (PDL) on our website for the most up-to-date list of approved drugs. See the Common Over-the Counter (OTC) Medication list on our website for list of covered drugs.	• All maintenance medications are covered for a 31-day supply. Ninety (90)-day supplies are allowed for certain oral diabetic, cholesterol, asthma, and high blood pressure medications. • We will only cover over-the-counter medicine with a prescription. • There are no limits on the number of prescriptions, but some may require prior approval. • Specialty medications must be dispensed by a participating specialty pharmacy. An initial (first fill) is allowed at a local retail pharmacy in urgent situations. • We do not cover: – Drugs for erectile dysfunction – Diet aids – Cosmetic hair growth drugs
Physical, occupational and speech therapy  Some therapy services require an approval from your PCP and/or us.	Medically necessary therapy services given in: • A doctor's office • A hospital • Another outpatient setting	• Members 21 years of age and older have a limit of 75 combined visits per benefit year. • Members 21 years and younger who receive therapy from a private practitioner have a limit

Benefit	Coverage	Limits
		of 105 hours or 420 units per benefit year.
Physician (doctor) services No copays for: • Preventive care for members ages 21 and older • Urgent care visits for members ages 21 and older • Members under age 19 $3.30 copay for PCP and specialist visits. Please see the first page of Part 4 for exclusions.	• Visits to PCPs, specialists or other providers • Routine physicals for children through the month of their 21st birthdays • Adult well-visits	• We do not cover routine physicals for a job or camp programs. • We cover adult well-visits once every two years.
Podiatry services $1.15 copay for members.	• Medical or surgical treatment of disease, injury or defects of the foot • Routine foot care that includes cutting or removing corns and calluses, as well as nail trimming under certain conditions	Services must be medically necessary to be reimbursed.
Pregnancy and maternity services No copays for preventive care or urgent care visits for members ages 21 and older.	• Prenatal visits and routine care • Referrals to maternal fetal medicine specialists for high-risk pregnancy and after-delivery care when medically necessary • Routine prenatal ultrasounds • Sonograms • Services you receive from a certified nurse-midwife • Tests you need, like HIV testing, treatment and counseling ○ Pregnant members may refuse to take an HIV test • CenteringPregnancy™ group prenatal care services • Birthing center services • Vaginal childbirth and cesarean section (C-section)	• Limit of three routine prenatal ultrasounds per pregnancy. For more ultrasounds, you will need a medical diagnosis and prior authorization. • CenteringPregnancy services are for women ages 12 to 55. We'll cover up to 10 visits as long as they: – Happen before your baby arrives. – Last at least 1.5 hours. – Have between 2 and 20 people in the group.

Benefit	Coverage	Limits
	• Up to 48 hours in the hospital after a vaginal delivery • Up to 96 hours in the hospital after a C-section • Newborn hearing screenings • A follow-up visit for the mother and baby within two days of an early discharge when the treating doctor orders it • Postoperative visit after a C-section • Postpartum visit with a provider 21–56 days after delivery • Electric breast pump for mothers who wish to breast feed and are not able to due to mother's or infant's medical condition • Long-term electric breast pump needs with a hospital-grade electric breast pump rental for mothers with a baby in the neonatal intensive care unit	
Preventive and rehabilitative services for primary care enhancement	Members who may have medical risk factors have their: • Health status assessed. • Risk factors identified. • Goal-oriented plan of care completed or changed.	
Psychiatric assessment services	• Psychiatric assessment services you may get in your PCP's office • Psychiatric diagnostic interview exams given by a: – Doctor – Psychiatrist – Psychologist – Psychiatric nurse • Behavioral health services given in the ER	We limit assessments to one per member every six months. We may approve more reviews when medically necessary.
Transplant services 	All related services 72 hours prior to admission, post-transplant services upon discharge by Medical University Hospital Authority (MUHA) and post-transplant pharmacy services for these transplants:	Regular Medicaid covers the transplant surgery, except for corneal transplants.

Benefit	Coverage	Limits
	• Kidney • Bone marrow, including: – Autologous inpatient and outpatient – Allogeneic related and unrelated – Cord – Mismatched • Small bowel • Heart and heart/lung • Liver, including: – Liver with small bowel – Liver/pancreas – Liver/kidney • Lung • Multivisceral • Pancreas and kidney/pancreas We also cover corneal transplants.	The Medicaid Quality Improvement Organization (QIO) must preapprove all transplants except corneal transplants.
Vaccinations	• Vaccinations given through the Vaccine for Children (VFC) program for children ages 18 and younger • Some vaccinations for adults ages 19 and older, including: – Serogroup B meningococcal (MenB) – Measles, mumps and rubella (MMR) – Varicella (VAR) – Measles, mumps, rubella and varicella (MMRV)	
Vision services No copay for routine vision services. $3.30 copay for members 19 years of age and older who see an optometrist or ophthalmologist (eye doctor) for **medical** reasons.	For members under 21 years of age, we cover: • Well-baby, well-child and well-teen checkups. • One eye exam, pair of eyeglasses (frames and lenses) and related fitting every 12 months. For members 21 years and older, we cover: • One eye exam annually. • A pair of eyeglasses (frames and lenses) and related fitting every 24 months.	

Part 5: How to use your health plan

There are many moving parts to your health care plan — so we have made it easier to understand. This section will explain how to use your health plan and the benefits we offer you.

Your ID cards

You should have received your new Healthy Blue member ID card in the mail. Always carry your South Carolina Healthy Connections ID card and your Healthy Blue ID card with you. You'll need to show both of these cards to your primary care provider (PCP), hospital staff, or other provider when you get health care. You are the only one who can use your Healthy Blue ID card. If you let someone else use your ID card, we may not be able to keep you on our plan.

Here's a sample of what your Healthy Blue ID card will look like:

Your ID card includes:

- Your name.
- Your member ID number.
- Your PCP's name and phone number.
- Our name, address and toll-free Customer Care Center (CCC) phone number.
- The phone number for 24-Hour Nurseline.
- The phone number for Pharmacy Member Services.
- What to do in an emergency.

You will receive a new ID card if:

- You change your PCP.
- You lost your ID card and request a new one.

If you have not received your Healthy Blue ID card yet or if you need a new one, call the CCC number at the bottom of this page. **Please let us know if your Healthy Blue ID card is stolen. We will tell the South Carolina Department of Health and Human Services (SCDHHS) and send you a new Healthy Blue ID card**.

Customer Care Center (CCC): 866-781-5094 (TTY 866-773-9634) Mon.–Fri. 8 a.m.–6 p.m.
24-Hour Nurseline: 866-577-9710 (TTY 800-368-4424) 24 hours a day, seven days a week

Primary care provider (PCP)

What is a PCP?

Your Healthy Blue ID card will have the name of the PCP you chose or your assigned PCP if you did not choose one. A PCP is your main health care provider. They will give you your primary care services. Your PCP must be in our network. If you were under the care of a PCP who is not part of our network when you became a member of our health plan, you may be able to stay with that doctor for a short time. Please call the CCC to find out.

A PCP may be any of these types of providers:

- Pediatrician (a doctor who takes care of babies and children)
- Family and general practitioner (a doctor who takes care of babies, children, and adults)
- Internist (a doctor who takes care of adults by treating problems that have to do with the organs inside the body)
- Obstetrician/gynecologist, also called an OB/GYN (a doctor who only takes care of women)

Clinics, such as public health departments, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) also may be PCPs.

A woman may choose an OB/GYN as her PCP. She also may go to an OB/GYN without an approval from her PCP anytime she needs to see a doctor.

PCPs for pregnant members and newborn babies

If you are pregnant, call us right away at the CCC number at the bottom of this page. If you are in the last three months of your pregnancy and you just became a member of this health plan, you can stay with your current OB/GYN whether that doctor is in our network or not.

When you call us, we will sign you up for our no-cost New Baby, New Life^{SM} program. This prenatal program will help you learn how to take care of yourself and your baby during and after your pregnancy. We also can help you choose a PCP for your baby.

Enrolling a newborn baby

Call us as soon as you know you are pregnant. **SCDHHS will enroll your baby on the same plan you have the month they are born.** You may choose to enroll your newborn into another plan after you deliver by calling Healthy Connections Choices at **877-552-4642 (TTY 877-552-4670)**.

If you have not called us yet to choose a PCP for your baby, you can call after your baby is born. Call us at the CCC number at the bottom of this page. You can change your newborn's health plan within 90 days of their enrollment. If you do not choose a PCP for your baby, we will choose one for you.

Initial health exam

We ask all our new members to see their PCPs within the first 90 days of joining our health plan. The first meeting with your new PCP is important. Your PCP will:

- Get to know you.
- Ask you questions about your health.
- Help you understand your medical needs.
- Teach you ways to make your health better or help you stay healthy.

Call your PCP today to set up this visit.

How to make an appointment with your PCP

Call your PCP's office to set up a doctor visit and tell them you are a Healthy Blue member. The number is on your ID card. Have your Healthy Blue ID card with you when you call. You may be asked for your member ID number.

Make sure to bring your South Carolina Healthy Connections ID card and your Healthy Blue ID card with you to your doctor visits.

Make sure to be on time for your doctor visits. Call your PCP's office as soon as you can if:

- You will be late.
- You cannot keep your appointment.

This will help shorten everyone's time in the waiting room. Your PCP may not be able to see you if you are late. Make sure you call your PCP if you need to change or cancel your appointment. The staff at your PCP's office can help you set up a new one.

Making an appointment when you are sick

Your PCP is there to see you if you are sick. Call your PCP, and tell the staff you are sick and want to see the doctor or speak to a nurse. The person who answers your call will need your name and a phone number where you can be reached. The office will call you.

What to do if your PCP's office is closed

If you need to call your PCP after office hours, leave your name and phone number with the answering service. Either your PCP or an on-call doctor will call you back. If you have an emergency, call **911** (or your local emergency number) or go to the nearest ER. You also can call 24-Hour Nurseline at the number listed at the bottom of this page.

Changing your PCP

Most of the time, it is best to keep the same PCP. That way, your PCP gets to know your health needs and history. You can change your PCP at any time for any reason. If you want to do so, call us. You can

also update your PCP through the online member portal at **HealthyBlueSC.com**. We want you to be happy with your PCP.

When choosing a PCP, think about what you want. Ask:

- Do I want a man or a woman for my PCP?
- What language does the PCP speak?
- Is the PCP's office open on weekends?

Answering these questions will help you find the PCP that fits you the best.

If you want to change your PCP, remember:

- You must choose a doctor who will see new patients. We can help you find one. A request to change your PCP may be denied if the PCP you want is not taking new patients.
- The PCP must be in our network.
- Your PCP change will go into effect on the day of request.
- You will receive a new ID card from us with your new PCP's name on it.
- You should ask for your medical records to be sent to your new PCP.

Your PCP may ask you to change your PCP if:

- We no longer work with your current PCP.
- You keep setting up doctor visits and not showing up for them.
- You are often late for your doctor visits.
- You are mean or rude to staff at your PCP's office.
- You disrupt your PCP's office.

If your PCP or specialist is no longer part of the Healthy Blue network, we will mail a letter to notify you. If we know in advance that the provider is leaving the network, you will receive the letter at least 30 days before the effective date. If we learn later that the provider is leaving, we will send the letter as soon as possible. We will send notification within 15 days after we learn of the provider's termination.

If you want to go to a provider who is not your PCP, call us first. We will try to make that provider your PCP. If you see a doctor who is not your PCP without an approval from us first, Healthy Blue will not pay for the service.

Provider directory

A provider directory is a list of all of the providers in our network. If you need a provider directory or help choosing a doctor who is right for you, call us. You also can find a PCP at **HealthyBlueSC.com**. We add new providers and hospitals to the online provider directory as soon as they join our network. So you will always find the most current details online. If you do not have access to the internet, please call our CCC number at the bottom of this page. We will send you a printed copy of the provider directory at no charge.

To find the online provider directory, visit our website at **HealthyBlueSC.com** and select **Find a Doctor**. From there, you can:

- Create and print a directory.
- Search for a provider by your ZIP code.
- Search for facilities such as urgent care clinics, X-ray imagery, and more.

This will bring up a list of providers in your area. This list will also show you if a doctor is taking new patients.

The directory will also list the addresses, phone numbers, languages spoken, and when the provider's offices are open. Look in the provider directory to find a PCP who is right for you and your family.

- PCPs for children are listed under "Family Medicine," "General Practice," or "Pediatrics."
- PCPs for adults are listed under "Family Medicine," "General Practice," or "Internal Medicine."
- Pregnant members should look for providers listed under "Obstetrics & Gynecology" or "Family Medicine."

To find out even more about a PCP or a specialist, like the doctor's specialty, medical school, residency training, or board certification, look at your provider directory, or visit these websites:

- American Medical Association (AMA) at apps.amaassn.org/doctorfinder/home.jsp.*
  This will take you to the Doctor Finder tool.
- Certification Matters at **certificationmatters.org**.*****
  - Select **Is My Doctor Board Certified?** This will let you search for a provider.

* These links lead to third-party websites. Those organizations are solely responsible for the privacy policies and contents on their sites.

Important note

Some hospitals and providers may have a moral objection to performing some of your covered services. Some of these services include:

- Family planning and supplies.
- Contraceptive services (including emergency contraception).
- Sterilization (includes tubal ligation at the time of labor and delivery).
- Abortion (choosing to end a pregnancy).

Customer Care Center (CCC): 866-781-5094 (TTY 866-773-9634) Mon.–Fri. 8 a.m.–6 p.m.
24-Hour Nurseline: 866-577-9710 (TTY 800-368-4424) 24 hours a day, seven days a week

If you want to receive these services, but your provider or hospital will not perform them, call the CCC phone number at the bottom of this page. We will help you find a provider or hospital that will.

Physician incentive plans

You have the right to know if your PCP is part of a physician incentive plan through Healthy Blue. To learn more about this, call us at our CCC number on the bottom of this page.

Prior authorization (an approval from Healthy Blue)

Your PCP will need to receive an approval from us for some services to make sure they are covered. This means that both Healthy Blue and your PCP (or specialist) agree that the services are medically necessary.

Medically necessary services are the services covered by the State Medicaid program, including their treatment limits. When a service is medically necessary and it is a covered benefit, Healthy Blue will pay for it as long as you are eligible.

Getting an approval will take no more than 14 calendar days, or if urgent, no more than 72 hours. See **Part 6: What Healthy Blue covers** to check service limits. Your PCP can tell you more about this.

We may not approve the service you or your PCP asks for. We'll send you and your PCP a letter telling you why we would not cover the service. The letter also will let you know how to appeal our decision.

If you have questions, you or your PCP may call the CCC number at the bottom of this page. You also may write to us at:

Healthy Blue
P.O. Box 100124
Columbia, SC 29202-3124

You do not need an approval from your PCP for these types of care:

- Family planning and supplies
- In-network OB/GYN services
- Emergency care

If you want specialty care, we may ask your PCP why you need it. If you see a specialist or receive specialty services from a provider out of the network before you receive an approval from us, we will not pay for the services. If we deny a request to pay for specialty care, we will send you a letter that tells you why we denied it. The letter also will let you know how you can appeal the decision if you do not agree with the denial.

At times, the network may not have the type of doctor you need. You do not have to pay the cost to see a doctor outside your network if:

- Your PCP says you need care from that kind of doctor.
- We approve the request.

Routine nonurgent requests

Getting a decision will take no more than 14 calendar days. Healthy Blue may extend the decision time frame by up to an additional 14 calendar days if needed.

Urgent preservice requests

Getting a decision will take no more than 72 hours. There are certain situations where the urgent timeline may be extended:

- If Healthy Blue needs additional information, we may extend the time frame to receive the necessary information.
- The request does not meet the criteria for an expedited/urgent request.

If the request does not meet the requirements, it will be treated as a standard request and will be reviewed within 14 calendar days.

For all preservice requests, you, your authorized representative, or your provider may request an extension. You should call the provider who ordered the treatment or call the CCC phone number at the bottom of this page to request an extension of an authorization.

If Healthy Blue extends the time frame, we will send you a letter with the reason for the extension and tell you about your right to file a grievance if you disagree with the decision.

Making coverage decisions

Healthy Blue wants to make sure our members receive all of the medical services they need to maintain good health. To do so, we have to decide which services we will cover. Through a process called utilization management (UM), we work with local doctors and other health providers to decide which services are needed and proper for us to provide full coverage for our members. Medically necessary services are the services covered by the State Medicaid program, including their treatment limits.

You and your PCP always decide what is best for your health. If your doctor asks us to approve payment for certain health care services, we base our decision on two things: 1.) If the care is medically necessary. 2.) The health care benefits you have.

You also should know Healthy Blue does not pay Medicaid doctors or other health care workers who make UM decisions to:

- Deny you care.
- Say you do not have coverage.

- Approve less care than you need.

Availability of UM staff

For inbound calls related to UM, just call the toll-free CCC. If you have hearing or speech loss, call the TTY line. Health plan staff can make and receive calls during and after normal business hours. They can also help if you need an interpreter. When a staff member calls you back about approval for services, you will be told who is calling, their title, and for whom they work. We will tell you how to:

- Learn more about a request.
- Send a fax or leave a message with your contact information so someone can call you back the next business day.

Types of care

Routine care

Routine care is the normal care you get from your PCP to help keep you healthy, such as checkups. You may call your PCP to set up a visit for routine care. You should be able to see your PCP within four weeks from the date you call. You should not have to wait more than 45 minutes for your scheduled appointment.

Urgent care

An urgent medical condition is **not** an emergency, but needs medical care within 48 hours. Call your PCP if you have an urgent medical condition. If you cannot reach your PCP:

- Call us at **866-781-5094 (TTY 866-773-9634)**.
- Call 24-Hour Nurseline at **866-577-9710 (TTY 800-368-4424)**.
- Go to an urgent care facility. Call the CCC to find one near you.

Pregnancy care

As soon as you know you are pregnant, call the CCC. Our staff will make sure your doctor and the hospital where you will have your baby are both in your plan. If you are in the last three months of your pregnancy and you just became a member of our health plan, you will be able to stay with your current doctor even if that doctor is not part of your plan.

Our staff will also sign you up for our New Baby, New Life SM program. As part of this prenatal program, we will send you information on how to take care of yourself during pregnancy.

If you are pregnant, your doctor should set up your first prenatal care visit:

- Within 14 calendar days from the date you call if you are in your first three months of pregnancy.
- Within seven calendar days from the date you call if you are in the second three months of pregnancy.
- Within three business days from the date you call if you are in the last three months of pregnancy.

Call your doctor and ask to be seen right away if you think you have a high-risk condition with your pregnancy. High risk means because of your health issues or history, you may have a greater chance of having:

- Something going wrong with your pregnancy.
- A baby with a birth defect.

If you believe you are having an emergency, go to the emergency room (ER). You do not need to call us or your PCP before going to the ER.

Family planning

Family planning can help teach you how to:

- Be as healthy as you can be before you become pregnant.
- Keep you or your partner from becoming pregnant.
- Keep you from getting a sexually transmitted infection (STI) or sexually transmitted disease (STD).

Any member may see any family planning Medicaid provider without getting an approval from us first. This includes Medicaid providers who are not part of your plan, such as:

- Clinics
- OB/GYNs
- PCPs
- Certified nurse-midwives

Specialist care

Your PCP may send you to a specialist for specialty care or treatment. Your PCP's office staff can help you set up the visit. Your PCP will work with you to choose a specialist to give you the care you need.

- Tell your PCP and the specialist as much as you can about your health, so you all can decide what is best for you.
- Your PCP does not need to send an approval to the specialist before your visit if the specialist is in the network. Approval from Healthy Blue is required before your visit if the specialist is out-of-network.
- If you need an urgent doctor visit, you will receive one within 48 hours of your request.
- In-network specialists may treat you for as long as they think you need it.

If you see a specialist or receive specialty care from a provider for nonemergency care outside of your plan without receiving an approval from us first, you will have to pay for the treatment or service.

Special health care needs

If you have special health care needs, we allow you direct access to the right specialists for your condition and needs. This includes a standing referral to a specialist or having a specialist as a PCP if you need it. You need an approval to see a specialist if the specialist is not part of our plan.

Behavioral health (mental health/substance use disorder) care and subspecialty services

Handling the tasks of a home and family can lead to stress. Stress can lead to:

- Depression and/or anxiety.
- Marriage, family and/or parenting issues.
- Alcohol and drug misuse.

If you or a family member is having these kinds of problems, you can receive help. Call the CCC at the number at the bottom of the page for help.

You can also receive the name of a behavioral health specialist if you need one. If medically necessary, you may also receive:

- Inpatient behavioral health care.
- Outpatient behavioral health care and/or substance use treatment.
- Partial hospitalization for substance use treatment.
- Behavioral health rehabilitative treatment services.

You do not need a referral from your PCP to receive these services or to see a behavioral health specialist in your network.

If you think a behavioral health specialist doesn't meet your needs, talk to your PCP. They can help you find a different kind of specialist.

There are some treatments and services your PCP or behavioral health specialist must ask us to approve before you can get them. Your doctor will be able to tell you what they are. Call the CCC if you have questions about referrals and when you need one.

Part 6: What Healthy Blue covers

Below are the kinds of benefits you can receive through Healthy Blue when medically necessary. Keep in mind, some of these services must be approved by your primary care provider (PCP) and/or us before you receive them. You also must use a provider who is in your plan. If you receive nonemergency care from a provider outside your plan and need an approval from us before you receive the care, you will have to pay for the treatment or service.

Please see **Part 4: Benefit quick reference guide** for an easy-to-use chart of your benefits. If you want to know more about what is covered, call our Customer Care Center (CCC) number at the bottom of the page.

Audiology

These services involve checks and tests of ears. We cover children under 21 years of age. The benefit includes:

- Hearing aids and supplies to use with them.
- Hearing exams.
- Ear molds.

Behavioral health/Substance use services

These are services to help members with mental health, behavioral health, and substance use issues. If you think you need these services, talk with your doctor. They can help you decide what type of care can work best for you. If you need help receiving behavioral health care or substance use services, call the CCC.

Some of these services may need prior approval from us. Call the CCC to see if your behavioral health services need prior approval. You can also have your doctor call us for you.

Inpatient services

We cover these types of services, when medically necessary, for all members who receive the care in a contracted hospital or Division of Alcohol and Other Drug Abuse Services facility. Your doctor can send you to a certified psychiatric or substance use hospital that takes members your age, or you can choose one yourself. Your choice may require an approval if the specialist you choose is not part of our plan. Inpatient behavioral health and substance use services given in an acute care hospital are covered for members of all ages.

Covered providers

These types of services are given in an outpatient or office setting. Covered outpatient behavioral health and substance use care may be given by these types of providers:

- Psychiatrists
- Outpatient behavioral health facilities
- Psychologists
- Licensed social workers, licensed psychiatric nurses and other licensed master level providers
- Division of Alcohol and Other Drug Abuse Services facilities and professionals who work there
- Department of Mental Health Community Mental Health facilities and the professionals who work there
- Department of Education facilities and the professionals who work there
- Department of Juvenile Justice facilities and professionals who work there

Behavioral health outpatient services

We cover these types of outpatient services when medically necessary:

- Psychiatric diagnostic interview exams
- Psychotherapy services for group, family and individuals
- Psychological testing

Substance use services

These services are covered when given by the Department of Alcohol and Other Drug Abuse Services Commissions only:

- Social detoxification overnight services in a nonmedical setting to help a person stop using drugs or alcohol.
- Overnight residential services programs to help a person stay substance free.
- Partial Hospital Program (PHP) and Intensive Outpatient Program (IOP). These programs last several hours a day. PHP is longer than IOP.
- Psychiatric diagnostic interview exams.
- Group, family and individual psychotherapy.
- Psychological tests. Most are 30 to 60 minutes, but test times can vary.
- Psychological rehabilitative services provided by substance use professionals.
- Peer and family support visits with others who have similar substance use problems.

Chiropractic services

$1.15 copay for most members. See the first page of Part 4 for exclusions.

Medically necessary chiropractic services are:

- Offered to all members.
- Limited to using hands to put the bones of the spine back in line.

We will cover up to six visits per benefit year.

Customer Care Center (CCC): 866-781-5094 (TTY 866-773-9634) Mon.–Fri. 8 a.m.–6 p.m.
24-Hour Nurseline: 866-577-9710 (TTY 800-368-4424) 24 hours a day, seven days a week

Chronic renal disease

These services are for members with kidney problems that may not be resolved. These members also need routine dialysis to stay alive. We cover:

- Hemodialysis.
- Peritoneal dialysis.
- Other dialysis procedures.

Communicable disease services

These services help control and stop diseases from spreading from one person to another. These can include:

- Tuberculosis (TB).
- Sexually transmitted infections (STIs), like gonorrhea or syphilis.
- HIV or AIDS.

You may receive care for these diseases at any state public health agency. We will cover:

- Exams and reviews.
- Teaching you about health topics.
- Counseling.
- Contact tracing that follows the rules of the Centers for Disease Control and Prevention.
- Certain outreach care for direct observation therapy for TB.

We suggest you seek TB, STI, HIV or AIDS care through your PCP. If you cannot, you may receive this care from any Medicaid provider. You may also receive TB, STI, HIV or AIDS tests and counseling care from any public health agency.

Durable medical equipment (DME) and disposable supplies

$3.40 copay for most members. See the first page of Part 4 for exclusions.

DME is medical equipment that can be used again and again. Disposable supplies are supplies that cannot be used again and are thrown away. These are covered when medically necessary and used by a person who is sick or injured. We cover:

- Medical products.
- Surgical supplies.
- Wheelchairs. Power wheelchairs may be replaced every seven years.
- Traction equipment.
- Walkers.
- Canes.
- Crutches.
- Ventilators.

- Prosthetic devices.
- Orthotic devices.
- Oxygen.
- Hearing aids and accessories (parts used with the aid).
- Incontinence supplies.
- Diabetes supplies:
  - Your pharmacy benefit covers:
    - Blood glucose monitors, including continuous blood glucose monitors (CGMs).
    - Test strips.
    - Lancets and lancing devices.
    - Urine glucose test strips.
  - Your medical benefit covers:
    - One pair of diabetic shoes per year.
    - Three pairs of diabetic shoe inserts per year.

Limits:

- Some equipment needs approval from us first.
- Hearing aids and parts used with them only are for members under 21 years of age.
- We do not cover insulin pumps for type 2 diabetes.
- We do not cover wheelchair accessories that are not medically necessary. These include, but are not limited, to:
  - Crutch or cane holders.
  - Umbrellas.
  - Pillows.
- Blood pressure screening.
- Health education.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services/ well-child visits

These visits include health screenings, as well as diagnosis, treatment and shots for children through the month of their 21st birthdays. We cover:

- Comprehensive health and developmental history.
- Developmental assessment.
- Comprehensive unclothed physical exam.
- Appropriate shots.
- Dental assessment.
- Vision screening.
- Hearing screening.
- Anemia screening.

- Blood pressure screening.
- Health education.
- Lead toxicity screening.
- Laboratory tests.

Healthy Blue provides a summary of Preventive Health Guidelines for members on our website at **HealthyBlueSC.com**. Healthy Blue also makes these guidelines available to members and potential members upon request. If you need help to set up one of these visits, call our CCC number at the bottom of the page.

Emergency services

Call 911 (or your local emergency number) or go to the nearest emergency room (ER) right away for emergency medical care.

All emergency services are covered. You do not need an approval from us for any of these services. For more information, see **Part 9: Emergency and urgent care**. This section will tell you what to do if you have an emergency or need urgent care. After you receive emergency care, call your PCP within two days or as soon as you can for follow-up care.

Emergency transportation

This includes the use of a ground or an air ambulance to transport you to an ER if you have a medical emergency. You do not need an approval from us if you have an emergency.

Family planning

These services may help you if you want to know how to:

- Be as healthy as you can be before you become pregnant.
- Not become pregnant.
- Protect yourself from sexually transmitted infections (STIs).

We cover:

- Medical visits for birth control.
- Teaching you about family planning and supplies.
- Counseling.
- Birth control.
- Pregnancy tests.
- Tests for STIs.
- Sterilization (surgery to prevent pregnancy).
- Lab services for family planning.

You do not need an approval from your PCP for family planning care. You may use any certified nurse-midwife or family planning clinic that is a Medicaid provider. The Medicaid provider does not have to be a part of your network.

We do not cover:

- Surgery to reverse sterilization.
- Hysterectomy for sterilization.
- Fertility treatments, such as artificial insemination and in vitro fertilization.

Look in your provider directory to find a provider that offers these services.

Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services

$3.30 copay for most members. See the first page of Part 4 for exclusions.

If you go to one of these centers, we will cover:

- Preventive care.
- Primary care.
- Communicable disease services to help control and prevent disease.

Home health care

$3.30 copay per visit for most members. See the first page of Part 4 for exclusions.

These services include having a skilled nurse visit you in your home. We cover:

- Up to 50 home health visits per benefit year (July 1–June 30).
- A home health aide.
- Medical supplies and equipment fit for use in the home.
- Physical, occupational and speech therapy.

We do not cover personal care services.

Hospital services

Your PCP can send you to any hospital in your plan. Look in your provider directory to find a list of hospitals in your plan. You can find the provider directory on our website at **HealthyBlueSC.com**. You can also request a printed provider directory at no cost by calling the CCC. **Go to the nearest hospital in an emergency**.

Inpatient
Twenty-five dollar copay for most members. See the first page of Part 4 for exclusions. Inpatient hospital care means you have to stay overnight in the hospital.

We cover:

- A semiprivate room.
- Maternity services.
- Care in special units.
- Delivery rooms.
- Hysterectomies.
- Specialty care rooms.
- Operating rooms.
- Supplies.
- Medical tests.
- Taking X-rays.
- Drugs the hospital staff give you during your stay.
- Giving you someone else's blood.
- Radiation therapy.
- Chemotherapy.
- Dialysis treatment.
- Meals and special diets.
- General nursing care.
- Anesthesia.
- Anesthesia services for dental procedures when it's an emergency.
- The plan setup when you leave the hospital. This includes future care if you need it.
- Rehab in the hospital.
- Surgery.
- Surgery to repair the breast after a full or partial removal for any medical reason.

Limits:

- Inpatient hospital services are limited to general acute care hospital services listed above.
- Private rooms aren't covered unless medically necessary.

Outpatient

No copay for emergency room (ER) visits. Most members have a $3.40 copay for other outpatient services. See the first page of Part 4 for exclusions. Outpatient hospital care services are services you can receive at the hospital that do not require you to stay overnight.

We cover services you receive in an outpatient or ambulatory care setting, such as:

- Care to prevent illness.
- Care to find out what is wrong with you.
- Care to treat your health issue.
- Rehab.
- Outpatient surgical care.
- Emergency care.
- Treatment of renal disease.
- Neurodevelopmental or mental developmental assessment and testing for children under 21 years.
- Physical, occupational or speech therapy.
- Family planning.
- Dialysis.
- ER use.
- Drugs ordered by a doctor.
- Giving you someone else's blood.
- Services to prevent problems or find out what is wrong with you.
- Surgery that does not end in a hospital stay.
- Sterilization (surgery done to keep a woman from becoming pregnant).

Institutional long-term care facilities and nursing homes

We cover nursing home and rehab services at the skilled intermediate or subacute intermediate level of care. Healthy Blue covers care for 90 consecutive days when you're approved and admitted to a long-term care facility.

Healthy Connections will cover your care after the first 90 consecutive days. They'll disenroll you from Healthy Blue as soon as they are able, and you'll receive regular Medicaid.

Lab and X-ray services that need an approval

Your PCP may ask you to receive lab or X-ray services to find out what's wrong. These services can be:

- Computed tomography (CT).
- Magnetic resonance imaging (MRI).
- Magnetic resonance angiogram (MRA).
- Positron emission tomography (PET).
- Single-photon emission computed tomography (SPECT).

Some lab and X-ray services need our approval before you receive them. You must use a lab or facility in your plan.

We cover:

- X-rays and lab tests ordered by your doctor and done by a licensed provider.
- X-rays of the breast (mammogram).

Limits:

- Services must be medically necessary and ordered by a licensed provider.
- Some X-ray services may need an approval from your PCP.

Nonemergency transportation

We cover your nonemergency travel from a hospital to another hospital, facility, or your home when:

- It is medically necessary.
- A provider in our plan asks for the service.
- We give our approval before you receive the service.

We will cover transportation to an out-of-state medical facility if we approve the referral.

Transportation to other appointments may be covered by the state. Contact the transportation broker to find out more about available services. For more information, see https://www.scdhhs.gov/site-page/transportation-beneficiary-information.

Outpatient Pediatric AIDS Clinic services (OPAC)

OPAC gives specialty care, consulting and counseling services to HIV-infected and exposed Medicaid kids and their families. They also provide clinical and lab tests. The program will vary for each child:

- Kids born to HIV-positive mothers, but who do not test positive, will be seen every three months in a clinic until they are 2 years old.
- Kids who test positive will be seen in a clinic twice a week for eight weeks and then once a month until they are 2 years old.
- Kids who do not improve will stay in the OPAC program.

Pharmacy and over-the-counter products

$3.40 copay for generic or brand-name drugs for members 19 years of age and older. See the first page of Part 4 for exclusions.

Certain drugs need an approval first or have a limit based on medical necessity. Medically necessary services are the services covered by the State Medicaid program, including their treatment limits. See Part 10 to learn more about limits for certain drugs.

We have a Preferred Drug List (PDL) and formulary that tells you the drugs we cover. Find it and the nearest in-network pharmacy on our website at **HealthyBlueSC.com**. Drugs that are not on the PDL may require our approval for coverage.

We cover:

- All prescribed drugs ordered by your doctor that are approved by the Food and Drug Administration (FDA) and us.
- FDA-approved, over-the-counter drugs that are given because they cost less than other types of the drugs. These can include:
  - Pain relievers.
  - Over-the-counter birth control products, such as:
    - Condoms.
    - Foams.
    - Gels.
  - Drugs that reduce acid in the stomach.
  - Drugs that prevent or treat diarrhea.
  - Drugs that prevent or treat an ulcer.
  - Iron pills.
  - Laxatives and drugs that soften stool.
  - Lice treatment.
  - Drugs that prevent or treat fungus.
  - Drugs that reduce cold signs.
  - Drugs that reduce allergy signs.
  - Drugs that reduce swelling.
  - Hydrocortisone.
  - Drugs that reduce or prevent infection in the vagina.
  - Vitamins.
  - FDA-approved methods of contraception. These include:
    - Oral birth control.
    - Diaphragms.
- Drugs ordered to treat cancer if the drugs are believed to be safe and effective for the member's type of cancer.

Limits:

- All maintenance medications are covered for a 31-day supply. Ninety (90)-day supplies are allowed for certain oral diabetic, cholesterol, asthma, and high blood pressure medications.
- We only cover over-the-counter medicines:
  - With a prescription.
  - On our PDL.
- We do not cover diet aids and cosmetic or hair-growth drugs.
- We do not cover medicines from pharmacies outside of our plan.

Customer Care Center (CCC): 866-781-5094 (TTY 866-773-9634) Mon.–Fri. 8 a.m.–6 p.m.
24-Hour Nurseline: 866-577-9710 (TTY 800-368-4424) 24 hours a day, seven days a week

- Syringes or needles you do not use to inject yourself with medicine at home are listed under your medical benefit, not your pharmacy benefit.
- Syringes or needles you use to give yourself medicine at home, like insulin, are covered under your pharmacy benefit.
- Injections that must be given by your doctor (office-based injections) are covered under your medical benefit, not your pharmacy benefit.
- Specialty medications must be dispensed by a participating specialty pharmacy. An initial (first fill) is allowed at a local retail pharmacy in urgent situations.
- We do not cover drugs for erectile dysfunction.

There are no limits on the number of prescriptions, but some may require prior authorization.

Pharmacy prior authorizations

Some medications that are not on the PDL may require a prior authorization. A prior authorization can be submitted by your doctor on a Medication Prior Authorization Form that is available at **HealthyBlueSC.com**. Prior authorization requests are reviewed within 24 hours from the time they are received with all required information.

Physical, occupational and speech therapy

Some therapy services require an approval from your PCP and/or us. We cover therapy that is medically necessary. The therapy may be given in:

- A doctor's office.
- A hospital.
- Another outpatient setting.

During your treatment, we may check to see if the therapy is helping you.

Limits:

- Members older than 21 years have a limit of 75 combined visits per benefit year.
- Members 21 years and younger who receive therapy from a private practitioner are limited to 105 hours (420 units) per benefit year.

Physician (doctor) services

No copay for preventive care or urgent care visits for adults 21 years and older. $3.30 copay for PCP and specialist visits. See the first page of Part 4 for exclusions.

We cover:

- Visits to PCPs, specialists (with an approval from your PCP first, when needed), or other providers. Refer to **Part 4: Benefit quick reference guide** for the correct copay amount based on specialist type.
- Circumcision done at the hospital or doctor's office up to 1 year old.
- Routine physicals for children through the month of their 21st birthdays, sometimes called well-child visits or EPSDT checkups.
- One adult well-visit for members 21 years of age and older every two years.

We do not cover routine physicals for a job or camp programs.

Podiatry

We cover all members. There is a $1.15 copay.

Pregnancy and maternity

When you know you are pregnant, call the CCC number at the bottom of this page. Our staff will make sure your doctor and the hospital where you will have your child are both in your plan. If you joined our health plan in the last three months of your pregnancy, then you may stay with the doctor you have now even if they are not in your plan.

We cover:

- Doctor visits and all expert care for pregnancy, problems that have to do with the pregnancy, and after-delivery care when medically necessary.
- Services you receive from a certified nurse-midwife.
- Up to three sonograms.
- Tests you need, like HIV tests, treatment and counseling. A pregnant member may choose not to take an HIV test.
- Birthing center services.
- CenteringPregnancy group prenatal care services for members ages 12 to 55 to discuss maternal and infant health with clinical supervision and support.
  - You can find approved sites in South Carolina that provide CenteringPregnancy services on the Centering Healthcare Institute website.
  - We will cover up to 10 visits before your baby is born as long as they:
    - Last at least 1.5 hours.
    - Have between 2 and 20 people in the group.
- Vaginal childbirth and cesarean section (C-section) when medically necessary.
  - You may stay in the hospital 48 hours after a vaginal delivery.
  - You may stay in the hospital 96 hours after a C-section.
- Newborn exams, like hearing screenings.
- Routine newborn circumcision done while the baby is still in the hospital after birth.

  - After that, we will cover circumcision done in the doctor's office up to 1 year old.
  - You will need our approval first if the baby is more than 30 days old.
- A follow-up visit for the mother and the child within two days of an early discharge when the treating doctor orders it. An early discharge is a hospital stay less than two days for vaginal childbirth and less than four days for a C-section.

When you call to tell us you are pregnant, you are automatically enrolled in our New Baby, New Life℠ program. This prenatal program will help you learn how to take care of yourself while you are pregnant and after you deliver your baby. You will also receive information and support from My Advocate®. My Advocate uses calls, text messages, and a smartphone app to help you get in touch with case managers and learn more about topics like:

- Pregnancy and postpartum care.
- Well-child care.
- Dental care.
- Immunizations.
- Healthy living.

My Advocate is an independent company that administers prenatal program support on behalf of BlueChoice HealthPlan.

When you tell us you are pregnant, we will send you a prenatal packet that includes:

- Educational booklets.
- A brochure to provide you with tips and tools to help you make healthy choices before and after your baby is born.
- Information on how to reach a nurse 24 hours a day for questions.
- Information on how you can earn rewards for going to your prenatal visits.

We also have nurses who can help you connect to services in your community and provide you education and support throughout your pregnancy.

After you deliver your baby, we will send you information on:

- How to receive a free electric breast pump for nursing mothers.
- Caring for yourself and your baby.
- How to earn rewards for going to your postpartum visit between 21–56 days after you deliver and for taking your baby to well-child checkups.
- The "baby blues" and postpartum depression.
- A family life plan.

Preventive and rehabilitative services to improve primary care

Members who may have medical risk factors can have their:

- Health status assessed.
- Risk factors pointed out.
- Goal-oriented plan of care done or changed.

Psychiatric assessment services

We cover psychiatric assessments you may receive in your PCP's office. We also cover the following services that may be given by these providers:

- Psychiatric diagnostic interview exam provided by a doctor, a psychiatrist, a psychologist or a psychiatric nurse
- Behavioral health services given in the ER

Limits:
We limit assessments to one per member every six months. We may approve more reviews if medically necessary.

Transplant services

Transplant services are covered by regular Medicaid except for the following:

- Kidney: Healthy Blue is responsible for:
  - All related services 72 hours before admission.
  - Post-transplant services upon discharge by a Medical University Hospital Authority (MUHA).
  - Post-transplant pharmacy services.
  - The kidney transplant is covered by regular Medicaid.
- Corneal: Healthy Blue is responsible for the transplant and:
  - Pre-transplant services up to 72 hours before admission.
  - Post-transplant services after discharge by a MUHA.
  - Post-transplant pharmacy services.
- Bone marrow (autologous inpatient and outpatient, allogeneic related and unrelated, cord, and mismatched), pancreas, heart, liver, liver with small bowel, liver/pancreas, liver/kidney, kidney/pancreas, lung and heart/lung, multivisceral, and small bowel: Healthy Blue is responsible for:
  - All related services 72 hours prior to admission.
  - Post-transplant services upon discharge.
  - Post-transplant pharmacy services.
  - The bone marrow transplant is covered by regular Medicaid.

Other transplants may be covered by regular Medicaid. You or your doctor may call us to learn more.

Limits:
All transplant services, except corneal transplants, must be approved by the Quality Improvement Organization (QIO) before you get the service. QIO is an organization SCDHHS has contracted to approve transplant services. The QIO will review all Medicaid referrals for organ transplants and issue an approval or a denial.

Vision services

No copay for routine vision services. $3.30 copay for members 19 years of age and older who see an optometrist or ophthalmologist (eye doctor) for **medical** reasons.

For members 21 years of age and older, we cover:

- One eye exam every 12 months.
- One pair of eyeglasses (frame and lenses) and related fitting every 24 months.

For members under 21 years of age, we cover:

- Well-baby, well-child and well-teen checkups.
- One eye exam every 12 months.
- One pair of eyeglasses (frames and lenses) and related fitting every 12 months.

We work with Vision Service Plan (VSP) to offer routine vision benefits. You can find VSP providers on our provider directory at **HealthyBlueSC.com** or on the VSP website at vsp.com*.

If you have questions about your vision benefits, call VSP at **800-877-7195 (TTY 800-428-4833)** or send an email to imember@vsp.com.

VSP is an independent company that administers vision benefits on behalf of BlueChoice HealthPlan.

* These links lead to third-party websites. Those organizations are solely responsible for the privacy policies and contents on their sites.

Part 7: What regular Medicaid covers

Regular Medicaid may cover some services that Healthy Blue does not cover. If you have questions or want to know more about what regular Medicaid covers, call Healthy Connections at **888-549-0820 (TTY 888-842-3620)**. Here are some services regular Medicaid covers:

- Dental care for children under 21 years of age.
- Adult dental care for members 21 and older, including:
  - Up to $750 per year to use for covered dental services, like cleanings, X-rays and fillings.
  - Free emergency dental services from an oral surgeon when medically necessary.

- Developmental Evaluation Clinic (DEC). These services are used to find and help members who may have a delay in their development, or a behavioral, learning, or other health issue that disables them.
- Long-term care like:
  - Care in a nursing home for more than 90 consecutive days. If you stay in the nursing home for 90 consecutive days, you will be disenrolled from Healthy Blue and re-enrolled in regular Medicaid.
  - Home-based care.
- Care from groups in the area where you live.
- Head injury rehab care.
- Intermediate care settings for individuals with intellectual disabilities.
- Organ transplants, except corneal transplants, which we cover.
- Transport not for an emergency.
- Home and Community-Based Services waiver.
- Services to keep you from becoming pregnant given by Medicaid Adolescent Pregnancy Prevention Services.
- A second opinion. This is your right to see one more doctor to receive their opinion about how to treat your health issue, including an out-of-network doctor, if necessary. A second opinion from an out-of-network provider requires prior authorization.
- State institution services.
- Services given by Community Developmental Disability Organizations.
- Targeted case management, including services to help you receive medical, social, educational, and other needed services.
- School-based services.
- Hospice care approved by KePro.

Other state agencies may help with:

- Children in foster care.
- Emotionally disturbed children.
- Children in the juvenile justice system.
- Adults with sickle cell disease.
- County and state-linked services.
- Vital public health services.
- Direct observation therapy (DOT) for TB.
- Diseases you need to report.
- Women, Infants, and Children (WIC) referrals.

Part 8: What Healthy Blue and regular Medicaid do not cover

Here are some benefits and services Healthy Blue and regular Medicaid do not cover:

- Medical equipment and supplies:
  - Used only for your comfort or hygiene.
  - Used for exercise.
  - Still being tested or studied.
  - Used for the same thing, if you already have one.
  - Used only to add to the comfort in a room or home, such as:
    - Air conditioning.
    - Air filters.
    - A machine that makes the air cleaner.
    - Exercise equipment.
    - Spas.
    - Swimming pools.
    - Elevators.
    - Supplies for hygiene or looks.
- Care you received for health problems that had to do with work, if they may be paid for by:
  - Workers' compensation.
  - Your employer.
- Any service or care you received before you joined Healthy Blue.
- Any services or supplies not medically necessary.
- Personal or comfort items given to make things easy for:
  - You.
  - Your family.
  - Your primary care provider (PCP).
  - Other providers.
- Treatments still being tested or studied.
- Christian Science nurses and Christian Science sanitaria.
- Private-duty nurse services.
- Standard assisted-living services for those who live in an adult care home.
- Surgery done to reverse sterilization.
- Fertility treatment, such as artificial insemination or in vitro fertilization.
- Services and procedures related to gender transition.
- Drugs that are not approved by the U.S. Food and Drug Administration (FDA).
- Weight-loss drugs or diet aids.
- Cosmetic and hair-growth drugs.

- Abortion services unless they are needed to save a mother's life or to end a pregnancy caused by rape or incest.
- Syringes or needles your doctor did not order.
- Syvek patch.
- Acupuncture.
- Cosmetic surgery done to change or reshape normal body parts so they look better. This does not apply to surgery done to give you back the use of a body part or to correct a defect caused by an injury.
- Routine physicals for a job or camp programs.
- Any service not listed as covered.
- Services from a provider inside or outside the network you did not receive an approval for when it was needed.
- Services you receive outside the U.S.
- Services for your personal care, like help with:
  - Dressing*
  - Feeding*
  - Making food*

* Please note these services may be available in special circumstances but may require prior authorization.

Part 9: Emergency and urgent care

What is an emergency?

An emergency is a medical condition with severe signs (like severe pain or active labor) that a person with average knowledge of health and medicine could reasonably think not receiving medical care right away may:

- Place your health or the health of an unborn child at risk.
- Impair a body function.
- Cause dysfunction of a body part or organ.

You should go, or have someone take you, to the emergency room (ER) when you:

- May die.
- Have chest pains.
- Cannot breathe.
- Are choking.
- Have passed out.
- Are having a seizure.
- Are sick from taking poison.
- Are sick from taking too many drugs.
- Have a broken bone.
- Are bleeding a lot.
- Have been attacked.
- Are about to have a baby.
- Have a serious injury.
- Have a severe burn.
- Have a severe allergic reaction.
- Have an animal bite.
- Have plans to seriously hurt yourself or someone else.

The emergency services must be given by a doctor qualified to give emergency care.

What to do in an emergency

Call 911 (or your local emergency number) or go to the nearest ER for emergency medical care right away.

Go to the nearest hospital if you think you have any of the problems listed above. You will be seen as soon as possible. For emergency transport, call **911** or your local emergency number. You do not need an approval from us first when it is an emergency.

There may be other times you should go to the ER that are not on the list. If you are not sure, call **911** (or your local emergency number) or 24-Hour Nurseline at **866-577-9710 (TTY 800-368-4424)**. If you think you have an emergency, you do not need to call us or your doctor for an approval before you go to the ER.

As our member, you may use any hospital or other setting for emergency care. If you get sick while out of town or out of the state you live in and **you have a medical emergency**, go to the nearest ER or call **911** (or the local emergency number).

If you are sick while you are out of town or out of the state you live in and **you do NOT have an emergency** or an urgent condition, call your primary care provider (PCP) to set up a time to see them when you are back home. You can also call your PCP's office or 24-Hour Nurseline to ask for medical advice.

You are covered for emergency care within the U.S. even if the provider is not part of your plan. **Healthy Blue does not cover services you receive outside the U.S.**

You should call your PCP after the emergency so they can plan your follow-up care. You should do this for any emergency at home or away.

Post-stabilization care

Post-stabilization care is the services you receive after emergency medical care to keep your condition under control. We cover this type of care.

What to do when you need urgent care

An urgent medical condition means you need medical care within 48 hours. This is not the same as an emergency. If you need urgent care, call your PCP or go to an urgent care facility near you. Please call the Customer Care Center (CCC) if you need help finding an urgent care facility.

If you cannot reach your PCP, you can call the CCC or 24-Hour Nurseline phone numbers at the bottom of this page.

Part 10: How to have your prescriptions filled

What may my doctor prescribe?

Healthy Blue uses a list of chosen drugs called a Preferred Drug List (PDL) to help your doctor choose which drugs to give you. A group of doctors and pharmacists checks this list of drugs every three months. They help make sure the drugs on the list are safe and useful. Even though a drug is on the list, your doctor will choose which drug is best for you.

Certain drugs on the PDL:

- Need an approval first.
- Have limits based on medical necessity.
- Are only covered for the condition they are approved for.

If you want us to cover a drug that needs our approval or is limited based on medical necessity, your doctor must send us a request with the medical records we need. We will let your doctor know if we approve the request. We will allow a 72-hour emergency supply of medicine while we decide on the request.

We must approve payment for drugs that are not on the list. If your doctor thinks you need to take a drug that is not on this list, your doctor will send us a request telling us why you need the drug. We will let your doctor know if we approve your request. If we deny the request, you will receive a letter from us telling you the medical reasons why.

If we deny your doctor's request for a drug, you may appeal the decision. You must ask for an appeal within 60 calendar days from the date on the letter. Please see the Appeals section for information about how to ask for an appeal.

If you would like to know if a drug is on our list, just use the Searchable Formulary on our website at **HealthyBlueSC.com**. You can also call Pharmacy Member Services 24/7 at **833-207-3118**.

Some drugs may hurt you if you take them at the same time. To protect your health and keep you safe, we will let your doctor and pharmacist know if we have a concern about the drugs you take.

Most of the time, we cover generic and over-the-counter drugs with a prescription. When a drug is available as a generic, the brand-name drug is usually not covered.

You may need to use one or more types of a drug before we will cover another drug as medically necessary. This is called step therapy. We check certain prescription drugs to make sure proper prescribing guidelines are followed. These guidelines help you get high-quality and cost-effective drugs.

Step therapy drugs included on the PDL will require preapproval if you have not tried one or more of the required drugs that must be tried first.

Therapeutic substitution is a program that tells you and your providers about alternatives to certain prescribed drugs. We may contact you and your provider to make you aware of these choices. Only you and your provider can decide if the therapeutic substitute is right for you.

If you leave another plan or regular Medicaid to join Healthy Blue, we will cover drugs needing an approval from us for 90 days after you join.

Limits:

- All maintenance medications are covered for a 31-day supply. Ninety (90)-day supplies are allowed for certain oral diabetic, cholesterol, asthma, and high blood pressure medications.
- A prescription is needed to receive over-the-counter medicine.
- We do not cover diet aids, cosmetic, or hair-growth drugs.
- We only cover the over-the-counter drugs on our PDL.
- Drugs are only covered for the condition they are approved for.
- Syringes and needles you use to inject yourself with medicines at home, like insulin, are covered under your pharmacy benefit. Syringes or needles you do not use to inject yourself with medicine at home, like insulin, are covered by your medical benefits, not your pharmacy benefits.
- Injections your primary care provider (PCP) must give you (office-based injections) are covered by your medical benefits, not your pharmacy benefits.
- Specialty medications must be dispensed by a participating specialty pharmacy. An initial (first fill) is allowed at a local retail pharmacy in urgent situations.
- Your pharmacy benefit covers these diabetic supplies:
  - Blood glucose monitors, including continuous blood glucose monitors (CGMs)
  - Test strips
  - Lancets
  - Lancing devices
  - Urine glucose testing strips
- Drugs for erectile dysfunction are not covered.
- We do not limit the number of different prescriptions you can have, but some prescriptions may require our approval.

If you have a problem with the prescription drug services we give you, please call Pharmacy Member Services at **833-207-3118 (TTY 711)**.

Part 11: Programs to help keep you well

People have different needs at every stage of life. Whether you are a man or a woman, a child or an adult, we offer programs to help you stay healthy and manage illnesses. These programs are free for our members to learn about and join. We hope you use them.

To find out more, read our Preventive Health Guidelines:

- Visit **HealthyBlueSC.com**.
- Call the Customer Care Center (CCC) number at the bottom of this page and ask for a copy at no cost to you.

For women:

- **Well-woman care** can help you stay healthy with routine exams, mammograms, Pap tests, and pelvic exams.
- **Family planning** can help teach you:
  - How to be as healthy as you can before you become pregnant.
  - How to avoid becoming pregnant.
  - How to prevent sexually transmitted infections (STIs) and HIV or AIDS.
- **Pregnancy and childbirth classes** to help you learn how to stay healthy while you are pregnant.
- **The New Baby, New Life℠ program** for ideas on how to stay as healthy as you can during pregnancy and after delivery.
- **No-cost electric breast pump**.
- **No-cost car seat** for your new baby.
- **Breastfeeding support** from 24-Hour Nurseline to answer your questions about breastfeeding. A nurse will give you the support you need to breastfeed your baby.

Call the CCC to let us know you are pregnant. We will send you details about care during pregnancy and how to receive a free baby car seat. Your care after the baby is born is important. You should set up a doctor visit 21 to 56 days after the baby is born.

For you and your child:

- **Well-baby, well-child and well-teen** visits for children up through the month of their 21st birthdays. During these visits, the doctor will:
  - Check the child's total health, hearing, vision, and teeth.
  - Give vaccines, if needed.
- During your visit, ask your doctor:
  - How your child can make healthy eating choices and be more active.
  - When you should bring your child in for the next visit.

Customer Care Center (CCC): 866-781-5094 (TTY 866-773-9634) Mon.–Fri. 8 a.m.–6 p.m.
24-Hour Nurseline: 866-577-9710 (TTY 800-368-4424) 24 hours a day, seven days a week

These services follow the American Academy of Pediatrics guidelines.

Discounts for your health:

- **The ChooseHealthy™** online store discount program so you can save on:
  - Vitamins and supplements.
  - Diet and sports nutrition information.
  - Home fitness equipment, books, videos, and DVDs.
  - And more.

Learn more about ChooseHealthy™ at choosehealthy.com*.

- **Alternative health specialists and services** like:
  - Acupuncturists
  - Massage therapists
  - Chiropractors
  - Dietitians
  - Fitness clubs
  - Exercise centers in South Carolina
  - Occupational therapy
  - Physical therapy
  - Podiatry

Medical insurance benefits for these services must be exhausted before using the value-added discount. Visits with chiropractors, occupational therapists, and physical therapists are only covered when medically necessary. To learn more, visit choosehealthy.com.

Please note that this program is not insurance. You should check any insurance benefits you have before using this discount program, as those benefits may result in lower costs to you than using this discount program. The discount program provides for discount specialty health care services from participating practitioners. You must pay for all health care services but will receive a discount from health care practitioners who are a part of the discount program. The discount program does not make payments directly to the participating practitioners in the discount program.

ChooseHealthy™ is a product of American Specialty Health Administrators, Inc., a subsidiary of American Specialty Health Incorporated (ASH).

- **Allergy relief products** through Allergy Control Products, Inc. To learn more:
  - Visit the website at allergycontrol.com*.
  - Call toll free at **800-ALLERGY (800-255-3749)**.

When you order, enter or mention the discount code BCBSSC15.

Customer Care Center (CCC): 866-781-5094 (TTY 866-773-9634) Mon.–Fri. 8 a.m.–6 p.m.
24-Hour Nurseline: 866-577-9710 (TTY 800-368-4424) 24 hours a day, seven days a week

- **Fitness centers** like Children's Fitness, Doctors Wellness Center, and other participating fitness centers. To learn how you can save, call the CCC number at the bottom of this page.
- **Discounts for Jenny Craig®**. To learn more:
  - Call **877-Jenny70 (877-536-6970**).
  - Go to **HealthyBlueSC.com**.

These are added-value discount programs. As a Healthy Blue member, you receive these services and discounts, as well as the benefits covered under your Healthy Blue program.

ChooseHealthy™, Jenny Craig® and Allergy Control Products, Inc. are independent companies that administer services on behalf of BlueChoice HealthPlan.

* These links lead to third-party websites. Those organizations are solely responsible for the privacy policies and contents on their sites.

Case management

Our Case Management (CM) program helps you manage your complex and special health care issues. When you sign up for our CM program, a case manager will work with you and your family to:

- Create a care plan that fits your life.
- Set up health care services.
- Get referrals and preapprovals for care.
- Send health records to your doctors when they need them.

We also have complex case management for members with serious physical or behavioral health care needs. We may call you about this program if we think it could help you.

If you, your caregiver, or your practitioner think you need case management services, or would like to learn more about the CM program, call the CCC number at the bottom of this page. A case manager will contact you to:

- Ask you about your health, support system and lifestyle needs.
- Explain how the program can help.
- Ask if you'd like to sign up.

Condition Care

A Condition Care (CNDC) program can help you receive more out of life. As part of your Healthy Blue benefits, we are here to help you learn more about your health, keeping you and your needs in mind at every step.

Our team includes registered nurses called CNDC case managers. They will help you learn how to better manage your condition, or health issue. You can choose to join a CNDC program at no cost to you.

What programs do we offer?
You can join a CNDC program to get health care and support services if you have any of these conditions:

- Asthma
- Substance use disorder
- Bipolar disorder
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- HIV/AIDS
- Hypertension
- Major depressive disorder – adult
- Major depressive disorder – child and adolescent
- Schizophrenia
- Coronary artery disease (CAD)
- Diabetes

How it works
When you join one of our CNDC programs, a CNDC case manager will:

- Help you create health goals and make a plan to reach them.
- Coach you and support you through one-on-one phone calls.
- Track your progress.
- Give you information about local support and caregivers.
- Answer questions about your condition and/or treatment plan (ways to help health issues).
- Send you materials to learn about your condition and overall health and wellness.
- Coordinate your care with your health care providers, like helping you with:
  - Making appointments.
  - Transportation to health care provider visits.
  - Referring you to specialists in our health plan, if needed.
  - Receiving any medical equipment you may need.
- Offer educational materials and tools for weight management and tobacco cessation (how to stop using tobacco, like quitting smoking).

Our CNDC team and your primary care provider (PCP) are here to help you with your health care needs.

How to join
We will send you a letter welcoming you to a CNDC program, if you qualify. Or, call us toll free at **888-830-4300 (TTY 711)** Monday through Friday from 8:30 a.m. to 5:30 p.m. local time.

When you call, we will:

- Set you up with a CNDC case manager to get started.

Customer Care Center (CCC): 866-781-5094 (TTY 866-773-9634) Mon.–Fri. 8 a.m.–6 p.m.
24-Hour Nurseline: 866-577-9710 (TTY 800-368-4424) 24 hours a day, seven days a week

- Ask you some questions about your or your child's health.
- Start working together to create your or your child's plan.

You can also email us at dmself-referral@healthybluesc.com.

Please be aware that emails sent over the internet are usually safe, but there is some risk third parties may access (or see) these emails without you knowing. By sending your information in an email, you acknowledge (or understand) third parties may access these emails without you knowing.

You can choose to opt out (we will take you out of the program) of the program at any time. Please call us toll free at **888-830-4300 (TTY 711)** from 8:30 a.m. to 5:30 p.m. local time Monday through Friday to opt out. You may also call this number to leave a private message for your CNDC case manager 24 hours a day.

Useful phone numbers
In an emergency, call **911**.

Condition Care
Toll free: **888-830-4300 (TTY 711)**
Monday through Friday, 8:30 a.m. to 5:30 p.m. local time
Leave a private message for your case manager 24 hours a day.

After-hours: Call 24-Hour Nurseline 24 hours a day, seven days a week
866-577-9710 (TTY 800-368-4424)

Condition Care rights and responsibilities
When you join a Condition Care program, you have certain rights and responsibilities.
You have the right to:

- Know details about us, such as:
  - Programs and services we offer.
  - Our staff and their qualifications (skills or education).
  - Any contractual relationships (deals we have with other companies).
- Opt out of CNDC services.
- Know which CNDC case manager is handling your CNDC services and how to ask for a change.
- Receive support from us to make health care choices with your health care providers.
- Ask about all CNDC-related treatment options (ways to manage your condition) mentioned in clinical guidelines (even if a treatment is not part of your health plan), and talk about options with treating health care providers.
- Have personal data and medical information kept private.

- Know who has access to your information and how we make sure your information stays secure, private and confidential.
- Receive polite, respectful treatment from our staff.
- Be given information that is clear and easy to understand.
- File complaints to Healthy Blue by calling **888-830-4300 (TTY 711)** toll free from 8:30 a.m. to 5:30 p.m. local time Monday through Friday and:
  - Receive help on how to use the complaint process.
  - Know how much time Healthy Blue has to respond to and resolve issues of quality and complaints.
  - Give us feedback about the Condition Care program.

You also have a responsibility to:

- Follow the care plan that you and your CNDC case manager agree on.
- Give us information needed to carry out our services.
- Tell us and your health care providers if you choose to opt out (leave the program).

Condition Care does not market products or services from outside companies to our members. CNDC does not own or profit from outside companies on the goods and services we offer.

You can log in to your secure account, or register, at **HealthyBlueSC.com** to ask us to join a CNDC program. You will need your member ID number to register (located on your member ID card).

Using your secure account, you can send a secure message and ask to join the program.

For your peace of mind

24-Hour Nurseline lets you talk in private with a registered nurse about your health anytime, day or night. Teens can talk to a nurse trained to handle teen issues. Just call 24-Hour Nurseline phone number at the bottom of this page.

By calling 24-Hour Nurseline, you may also access more than 300 audio health topics like:

- Guidelines to help you and your family see the doctor at the right times
- High blood pressure
- Diabetes
- Sexually transmitted infections (STIs)
- HIV or AIDS
- Alcohol (drinking) and drug problems
- How to stop smoking
- Pregnancy

How to receive other services

You also may receive help from a special program called Women, Infants, and Children (WIC). The WIC program gives healthy food to pregnant members and mothers of young children. WIC also will give you free news about foods that are good for you. If you want to know more about WIC, call your local health department.

You may want to participate in programs Healthy Blue does not cover. Call our CCC number at the bottom of the page if you think these programs may help you.

Part 12: Help with special services

Help in other languages

Healthy Blue offers you services to help meet your language and cultural needs. We use an interpreter service that works with more than 150 languages (including American Sign Language).

We want you to have the right care, so we offer you:

- Health education items in Spanish.
- Customer Care Center (CCC) staff able to speak your language.
- Someone who speaks your language on the phone 24 hours a day.
- Sign language and face-to-face interpreters.
- Doctors who speak more than one language.

If you do not speak English, we can provide an interpreter for you during your doctor visits. You or your doctor can call us at our toll-free CCC number at the bottom of this page to ask for one. Please let us know you need an interpreter **at least three days (72 hours) before your visit**. We are open Monday through Friday from 8 a.m. to 6 p.m. We will set up a face-to-face or phone interpreter at no cost to you.

If you do not speak English, we can help you receive language assistance services and translation of member materials. If you need help with the translation of our information, you may call our toll-free CCC or email us at GBD.Interpret@amerigroup.com.

Help for members with hearing or vision loss

Healthy Blue has a toll-free TTY line for members with hearing loss. The phone number is **866-773-9634**. This phone line is open Monday through Friday from 8 a.m. to 6 p.m. To receive the help you need after our office hours and on weekends, call Relay South Carolina at **800-735-8583** or dial **711**.

We offer this book and other items we print in other formats for members with vision loss. Call us if you need this book or any of our other items in other formats.

The Americans with Disabilities Act of 1990

We follow the rules in the Americans with Disabilities Act (ADA) of 1990. This means we cannot discriminate against you because of a disability. If you believe we have treated you differently because of a disability, you may file a grievance by calling our CCC number at the bottom of this page.

Part 13: How to resolve a problem with Healthy Blue

We care about the quality of service you receive from our health care providers and us. If you have a problem with the level of service you receive, we would like to talk with you. Here are some of the issues we can help you with:

- Access to health care
- Care and treatment by a doctor
- Issues with how we do our business
- Any aspect of your care

Who may file a grievance or appeal

You can file a grievance or appeal with us. You can also choose someone to act on your behalf such as a relative, provider or an attorney.

If you are not happy with Healthy Blue, you or a person you choose to act for you can:

- File a grievance with us if you are dissatisfied with the quality of service or care you received.
- File an appeal with us for a benefit that:
  - Has been denied.
  - Had a partial approval (this includes the type or level of the service).
  - Has been changed.
  - Has been stopped.
  - Has been approved then stopped.
- Ask for a State Fair Hearing after you receive our final denial.

If you need help understanding the steps to file a grievance or appeal, or if you need help completing the forms, please call us at **866-781-5094 (TTY 866-773-9634)**. If you need an interpreter, we will provide one at no cost to you.

Grievances

A grievance is when you tell us you are not happy about anything other than an adverse benefit determination. An adverse benefit determination means we:

- Deny or limit the type or level of service you ask for.
- Reduce, delay or end a service that was approved before.
- Deny a payment for service in whole or in part.
- Fail to provide services or resolve grievances and appeals in a timely manner.

- Deny a request to receive services outside your network if you live in a rural area with only one managed care organization (MCO).
- Deny a request to dispute a financial liability, including cost sharing, copays, premiums, deductibles and coinsurance.

You or a person you choose to act for you can file a grievance with us. You may file a grievance if you:

- Are not happy with us.
- Feel a provider or the health plan has discriminated against you.
- Are not happy with the providers who work with us.

To file a grievance, you or the person you choose to act for you can:

- Call us at the Customer Care Center (CCC) number on the bottom of this page.
- Fill out a grievance form and send it to us. You can find grievance forms on our website at **HealthyBlueSC.com**. It is called the **Member Grievance Form**.
- Write a letter and send it to us.

You may file a grievance at any time. Tell us:

- Who is involved in the grievance.
- What happened.
- When it happened.
- Where it happened.
- Why you are not happy with your health care services.

Attach any papers you think will help us look into your issue. Our CCC staff can help you file a grievance. After you are done filling out the form or letter, mail it to:

Healthy Blue, BlueChoice HealthPlan of South Carolina
Grievance and Appeals Department
P.O. Box 62429
Virginia Beach, VA 23466-2429

If someone acting on your behalf sends a grievance for you, you are required to give us your written OK. You can mail us your written permission.

If you cannot mail the form or letter, you or the person you choose to represent you can call our CCC number at the bottom of the page.

If you (or the person you choose) calls into the CCC and files a grievance by phone, the grievance will be verbally acknowledged. The CCC associate will resolve the verbal grievance during the live call or no later than the end of the next business day by contacting you (or the person you choose) and providing a verbal resolution. If the CCC is unable to resolve the verbal grievance during the live call or by the end of the next business day, the Grievance and Appeals Department will be responsible to resolve the grievance.

Customer Care Center (CCC): 866-781-5094 (TTY 866-773-9634) Mon.–Fri. 8 a.m.–6 p.m.
24-Hour Nurseline: 866-577-9710 (TTY 800-368-4424) 24 hours a day, seven days a week

After we receive your grievance by phone or in the mail, we will tell you we received it by:

- Calling you (if your grievance can be resolved in one business day).
- Sending you an **Acknowledgement Letter** within five calendar days (if we need more than one business day to resolve your grievance).
- If your grievance deals with a medically urgent issue, we will resolve your grievance within 14 calendar days of when we receive it.

We will send you a **Grievance Resolution Letter** within 90 calendar days of the date we got your grievance. This letter will:

- Describe your grievance.
- Tell you what has been done to solve your problem.

Grievance extensions

Healthy Blue may take an extra 14 calendar days if:

- You or your representative asks for an extension to resolve your grievance.
- We need more information and time to make a decision.
- The extension is in the member's best interest.

If you do not ask for extra time, we will send you a written notice. It will let you know why we want the extension and your right to file a grievance if you do not agree with the decision.

For grievances about discrimination, you or your representative may also file a complaint of discrimination in court or with the U.S. Department of Health and Human Services Office for Civil Rights on the basis of:

- Race
- Color
- National origin
- Sex
- Age
- Disability

You can file a discrimination complaint:

- Electronically through the Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Ave. SW, Room 509F, HHH Building
  Washington, DC 20201

You or your representative can find the complaint form at hhs.gov/ocr/office/file/index.html*. You must file the form with the Office for Civil Rights within 180 days of the date of the alleged discrimination.

Appeals

You or the person you choose to act for you can ask for an appeal. This person can be anyone you choose, including an attorney. You can ask for an appeal if you receive an adverse benefit determination notice letter from us saying coverage for a medical service:

- Was denied.
- Was changed.
- Was approved then stopped.
- Was not given in a timely manner.

You can also ask for an appeal if you receive an adverse benefit determination saying we denied your request to dispute financial liabilities like:

- Copays.
- Premiums.
- Deductibles.
- Coinsurance.

You must ask for an appeal within 60 calendar days from the date on your adverse benefit determination notice. To ask for an appeal:

- Call us at **866-781-5094**.
- Fill out a **Member Appeal Request Form** and send it to us. You can find appeal forms at the places where you receive care, such as your doctor's office, or on our website.
- Write a letter and send it to us at:
  Healthy Blue, BlueChoice HealthPlan of South Carolina
  Grievance and Appeals Department
  P.O. Box 62429
  Virginia Beach, VA 23466-2429
  Fax: 866-216-3482

If someone acting on your behalf sends an appeal for you, you are required to sign a **Member Appeal Representative Form**. You may receive a **Member Appeal Representative Form** by calling the CCC number at the bottom of this page. When you call us, give your OK for someone to act on your behalf. We will send you the **Member Appeal Representative Form** for you to sign and return to us.

The CCC can help you file your appeal.

A parent, legal guardian, or conservator may file a grievance or appeal for a member who is:

- A minor.

- Incompetent (not able to act for mental reasons).
- Incapacitated (not able to act for physical reasons).

We will send you an **Acknowledgment Letter** within five calendar days. It will tell you we received your appeal request. We will resolve your appeal within 30 calendar days. We will send you an adverse benefit determination notice that tells you about our decision on your appeal. This letter will have:

- The date we made the decision.
- The specific reason about why we made the decision.

Expedited (rush) appeals

You can ask for an expedited (rush) appeal if you think waiting 30 calendar days for our decision may harm your health. When you ask for a rush appeal, be sure to tell us that you think waiting 30 calendar days will harm your health and why.

An appeals nurse will review your request for a rush appeal. If the appeals nurse thinks waiting 30 calendar days will harm your health, we will:

- Tell you our decision within 72 hours.
- Send our decision to you on the same day we make it.

If the appeals nurse thinks waiting 30 calendar days will not harm your health, we will send you a letter within two calendar days. The letter will let you know we will complete your appeal as quickly as we can within 30 calendar days. We will also call you to tell you what we decide. You may file a grievance if you disagree with our decision not to rush the appeal.

For all appeals

You or a person you choose to act for you, including your attorney, can ask to add up to 14 calendar days to your appeal time. You should ask to extend your appeal time if you need to send us more information about your appeal.

We also may add up to 14 calendar days to your appeal time if it is in your best interest to do so. We will call you and send a letter within two calendar days to tell you or your representative:

- The reason for the delay.
- You may file a grievance within two calendar days if you disagree with our decision to extend the review.

You have the right to file a grievance if you do not agree with our extension decision. We will resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

You or the person you choose to act for you can look at and ask to see your case file before or during the appeal process. Your case file includes medical records or other papers that are taken into account during your appeal. During your appeal, you or the person you choose to act for you can also:

- Show proof of what you say or claim.
- Show this proof in person or in writing.

You can ask us for a copy of what we used to make our decision. This includes:

- The benefit terms.
- Guidelines.
- Rules.
- Other reasons for our decision.

If your doctor wants to speak with the doctor reviewing your appeal, they can call our Utilization Management (UM) department at **866-902-1689, ext. 7979**.

You may keep your benefits for the appealed service while we review your appeal if all of these happen:

- You ask for the appeal within 10 calendar days from the date on your adverse benefit determination notice, or the intended effective date of the plan's proposed adverse benefit determination.
- The appeal has to do with coverage for a service that has been:
  - Delayed.
  - Reduced.
  - Stopped after it was approved.
- An approved provider ordered the service.
- The original period covered by the original authorization has not expired.
- You asked to extend your benefits.

They will be in effect until one of these happens:

- You stop your appeal request.
- Ten days have passed after we sent you a **Notice of Action** letter with our decision to uphold the first denial (unless you asked for a State Fair Hearing within that 10-day period).
- A State Fair Hearing officer upholds our denial.
- The time frame of an approved service has been met.

If the result of the appeal is the same as the original denial decision, you may have to pay for the costs of the services you were given while the appeal was pending.

Appealing a coverage decision

We may review some of the care your doctor says you need. We also may ask your doctor why you need a certain service. If we say "no" to paying for a service your doctor asks for, we will send you and your doctor a letter explaining why. This letter will also tell you how to appeal.

You or your doctor may appeal if we say "no" to a medical service or if we do not pay for a medical service. To learn more, please give us a call.

State Fair Hearing

If you are not happy with our response to your appeal, you or the person you choose to act for you has the right to ask for a State Fair Hearing with the South Carolina Department of Health and Human Services (SCDHHS) Division of Appeals and Hearings. The person you choose to act for you can be anyone, including a relative, provider or an attorney.

You must ask for a State Fair Hearing within 120 calendar days from the date of the **Notice of Resolution** letter. To ask for a State Fair Hearing, you or the person you choose to act for you can:

- Send a written request to:

  Division of Appeals and Hearings
  1801 Main St.
  P.O. Box 8206
  Columbia, SC 29202
  803-898-2600 or 800-763-9087
  Fax: 803-255-8206
  appeals@scdhhs.gov

Visit scdhhs.gov/appeals*. To learn more about State Fair Hearings, please call **800-763-9087**.

You may keep your benefits for the appealed service while you wait for your hearing if all of these happen:

- You ask for the hearing within 10 calendar days from the date you get the adverse benefit determination notice.
- The hearing has to do with coverage for a service that has been:
  - Delayed.
  - Reduced.
  - Stopped after it was approved.
- An approved provider ordered the service.
- The original period covered by the original authorization has not expired.
- You asked to extend your benefits.

You will be able to keep them until one of these happens:

- You stop your hearing request.
- A State Fair Hearing officer upholds our denial.
- The time frame of an approved service has been met.

If the result of the hearing is the same as the original denial decision, you may have to pay for the costs of the services you were given while the appeal was pending.

* These links lead to third-party websites. Those organizations are solely responsible for the privacy policies and contents on their sites.

Part 14: If we can no longer serve you

There are times when Healthy Blue or your doctor can no longer serve you.

You will not be covered by Healthy Blue if you no longer have Medicaid. The state of South Carolina decides:

- If a member is eligible for and stays enrolled in a health plan.
- If a member is kept out of or removed from a health plan.

Your Healthy Blue coverage goes into effect on the date shown on the front of your Healthy Blue ID card. It ends on the date given to us by the South Carolina Department of Health and Human Services (SCDHHS).

Your coverage could end for any of these reasons:

- You are no longer eligible.
- You move out of our service area. Healthy Blue's service area is in every county statewide in South Carolina.
- You misuse your Healthy Blue ID card.
- You behave in a way that keeps your doctor from being able to give services. This includes disrupting, threatening, not cooperating or being unruly.
- You commit fraud.
- You misrepresent yourself.

If you are unhappy about being removed from our health plan, see **Part 13 How to resolve a problem with Healthy Blue**. This part tells you how to file a grievance or ask for a State Fair Hearing. You may choose to disenroll from your plan within 90 days of joining or rejoining. If you choose to leave Healthy Blue, call Healthy Connections, the Medicaid enrollment broker, at **877-552-4642 (TTY 877-552-4670**), Monday through Friday from 8 a.m. to 6 p.m. If you do not speak English, someone can interpret for you.

Disenrollment

- You may ask to leave the plan with good reason or cause at any time. If your request to leave the plan for good cause is not approved, you may ask for a State Fair Hearing.
- You may ask to leave the plan without any reason during the first 90 days of your current 12-month enrollment period with Healthy Blue.
- If you do not ask to leave the plan during the first 90 days of your current enrollment period, you will stay enrolled for the full 12 months.

If you have any questions about this policy, call our Customer Care Center (CCC) number at the bottom of this page.

Part 15: Other things you may need to know

If you have questions that have not been answered yet, look through this section for the answers.

New medical treatments

Health care is always changing. We want you to benefit from any new treatments, so we review them often. A group of doctors, specialists, and medical directors decides if the treatment:

- Is approved by the government.
- Has shown in a reliable study how it affects patients.
- Will help patients as much as or more than treatments we use now.
- Will improve a patient's health.
- Is still being tested.

The review group looks at all of the data and decides if the treatment is medically necessary.

If your doctor asks us about a treatment the review group has not looked at yet, they will look at it. They will let your doctor know if the treatment is medically necessary and if we approve it.

Quality Improvement

At Healthy Blue, we always want to improve. Our Quality Improvement (QI) program helps us do this. The program:

- Assesses the health plan to help find ways to improve it.
- Tracks how happy you are with your doctor.
- Tracks how happy you are with us.
- Uses the data we learn to make a plan to improve our services.
- Puts our plan into action to make your health care services better.

You can receive details about our QI program by calling our Customer Care Center (CCC) number at the bottom of this page. This will include a description of the program and a report on our progress in meeting our improvement goals.

If you have other insurance

Please report all other insurance details to the program if:

- Your private health insurance ends.
- You get new insurance.
- You have questions about your other insurance.

Please call Healthy Connections at **888-549-0820 (TTY 888-842-3620)** if you have other insurance. You also can call your local county Medicaid office.

Having other insurance does not change whether you can have Medicaid. You need to report your other insurance so that Medicaid can coordinate with the other insurance.

Please note: Medicaid providers cannot refuse to see you because you also have private health insurance. If providers say they will see you as a Medicaid patient, they must take your private health insurance company as well.

How to receive help after normal office hours

The Healthy Blue CCC is open Monday through Friday from 8 a.m. to 6 p.m. You can leave a message if you call after normal office hours and on weekends. We will call you back the next working day.

If you call your doctor after normal office hours, you have three options:

- Find out how to reach an on-call doctor.
- Be connected to an on-call doctor.
- Receive a call back within 30 minutes.

For help anytime day or night, call 24-Hour Nurseline number at the bottom of this page.

What to do if you receive a bill

In most cases, you should not receive a bill from our providers. You may have to pay for charges if:

- You agreed ahead of time to pay for services that are not covered or approved by us.
- You agreed ahead of time to pay for services from a provider who does not work with us and you did not receive our approval ahead of time, but asked for the service anyway.
- You are responsible for a copay.

If you receive a bill and you do not think you should have to pay for the charges, call the CCC number at the bottom of this page. Have the bill with you when you call us so you can tell us the date of service, the amount charged, and why you were billed. Sometimes a provider may send you a “statement” that is not a “bill.” We will tell you if you have to pay it.

Out-of-area care

Healthy Blue’s service area is in every county statewide in South Carolina. If you are outside the Healthy Blue service area and need care that is not an emergency, call one of these right away:

- Your doctor
- 24-Hour Nurseline
- The CCC

We cover emergencies anywhere in the U.S. If you get care outside of our service area that is not for an emergency, you may have to pay for those services.

Remember: Do not use an emergency room (ER) for routine care.

Customer Care Center (CCC): 866-781-5094 (TTY 866-773-9634) Mon.–Fri. 8 a.m.–6 p.m.
24-Hour Nurseline: 866-577-9710 (TTY 800-368-4424) 24 hours a day, seven days a week

Advance directives (AD or living wills)

You have the right to make your health care decisions.

You have the right to:

- Choose what kind of health care you receive.
- Tell your doctor what types of health care you do not want.
- Create, change, or revoke your advance directives at any time.

You can tell your doctor what you want:

- In person.
- Over the phone.
- In writing.

If you are badly injured, not conscious or very ill, you may not be able to tell your doctor what you want. People need to know what you wish about your health care in case you are not able to talk. You may state what you wish in a health care power of attorney and a living will.

A living will lets your doctor know what types of treatments you do and do not want. A health care power of attorney lets you name someone to act on your behalf. This person can tell the doctor what types of care you want.

Choosing to sign a health care power of attorney or living will is private and important. Here are some important facts about health care powers of attorney and living wills:

- Living wills must be followed only if you cannot decide what to do for yourself due to an illness or injury. If you are pregnant, these papers will not put an end to your life support.
- If you do not have a living will or health care power of attorney saying what you want done, you will not have a say in what choices will be made or who will make them for you. Choices for you may be made by:
  - Relatives chosen by South Carolina law.
  - A person chosen by the court.
  - The court.

The best way to make sure what you want is done is to state your wishes in a health care power of attorney and a living will.

If you have questions about signing a health care power of attorney or living will, you should talk to your:

- Doctor.
- Minister.
- Priest.
- Rabbi.
- Other clergy who give advice.
- Lawyer.

It's important to let your family know how you feel about life support. You should talk to those you plan to have act on your behalf in your health care power of attorney. You need to make sure they want to help you and know what you want for your care.

We may give the information about advance directives to your family or surrogate if you join Healthy Blue and cannot receive the information or if you state whether or not you have made an advance directive due to incapacity or mental disorder. We will do this in the same way we give your family, surrogate, or other concerned persons materials about policies and procedures and in accord with state law. You will receive this information once you are no longer incapacitated and can receive the information.

Living will and health care powers of attorney forms are available in South Carolina. The living will form is called a Declaration of a Desire for a Natural Death. You may receive these forms from the SC Lieutenant Governor's Office on Aging by calling:

- **800-868-9095**
- **888-5WISHES (888-594-7437)**
- **803-734-9900**

You can also find these forms online at https://aging.sc.gov/programsinitiatives/legal-assistance-seniors.*

If you think your doctor or other health care provider is not following your advance directive requests, you can file a complaint with the SC Lieutenant Governor's Office on Aging by calling:

- **800-868-9095**
- **888-5WISHES (888-594-7437)**
- **803-734-9900**

Access to your medical records

Federal and state laws allow you to see your medical records at any time. Ask your doctor for your records first. If you have a problem obtaining your medical records from your doctor, call us.

Keeping your information private

We understand the importance of keeping your information private. It will be kept private between you, your health care provider, and us, except as the law allows. We have the right to receive information from anyone giving you care. This information is used to pay for and manage your health care. Refer to the **Notice of Privacy Practices** at the back of this book.

Program changes

If there are any changes to your health care program, we will tell you 30 calendar days before the change. Healthy Blue benefits may change without your say. If you have questions about program changes, call our CCC number at the bottom of this page.

Customer Care Center (CCC): 866-781-5094 (TTY 866-773-9634) Mon.–Fri. 8 a.m.–6 p.m.
24-Hour Nurseline: 866-577-9710 (TTY 800-368-4424) 24 hours a day, seven days a week

Part 16: Fraud, Waste, and Abuse: How do I identify and report it?

What is fraud?

Fraud means intentionally deceiving or misrepresenting information, knowing it could result in an unapproved benefit to yourself or another. Fraud can be:

- Using someone else's Social Security number to qualify for government assistance.
- A doctor intentionally billing for services they did not give.

If you commit fraud, you may lose your Medicaid coverage.

What is waste?

Waste is the overuse of services or careless practices that result in throwing away or the spending of health care or government resources in an unwise and wrong manner. Examples of waste are:

- Prescribing more medication than medically necessary.
- Providing more health care services than medically necessary.

What is abuse?

Abuse is an action resulting in unnecessary costs to government programs such as Medicaid. Abuse may also result in improper benefits to a member or improper payment to doctors. Examples of abuse include:

- Requesting and obtaining medications or medical equipment for someone else.
- Excessive use of the emergency room (ER) for nonemergency or routine care.

How to report fraud, waste, and abuse

If you believe a client (a person who receives benefits) or a provider (a doctor, dentist, counselor, etc.) has committed fraud, waste, or abuse, you have a responsibility and a right to report it. You also have the right to remain anonymous when reporting fraud, waste, and abuse. To report fraud, waste, or abuse, find out as many details as you can. You may report providers or clients to your health plan by:

- Calling our Customer Care Center (CCC) number at the bottom of this page.
- Calling the Healthy Blue Fraud Hotline at **866-847-8247** or emailing Medicaidfraudinvestigations@amerigroup.com.
- Faxing the Healthy Blue **Fraud Referral Form** to **866-494-8279**. The form is on our website at **HealthyBlueSC.com**.
- Writing to:
  Attn: MSIU
  Healthy Blue
  P.O. Box 66407
  Virginia Beach, VA 23466

- Calling the South Carolina Medicaid Fraud Hotline at **888-364-3224** or emailing fraudres@scdhhs.gov.

When you report a provider, give these details:

- Name, address and phone number of the provider
- Name and address of the place (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and place if you know it
- Type of provider (doctor, physical therapist, pharmacist, etc.)
- Names and phone numbers of other people who may be able to give us some of these details
- Dates of events
- A brief statement of what happened

When you report a client, give these details:

- The person's name
- The person's date of birth and Social Security number if you know it
- The city where the person lives
- Exact details about the waste, abuse, or fraud

Why should I care about fraud, waste, and abuse?

Everyone is hurt by fraud, waste and abuse. Millions of dollars are paid to those not entitled to receive services or cash. That money could be spent to provide more care to people in need or more benefits to you. Please call the Fraud Hotline or CCC if:

- You know someone is receiving care they are not supposed to receive.
- You suspect a doctor or lab of billing too much or billing for services not provided.

Part 17: Your health care rights and responsibilities

You or your doctor can obtain another copy of your member rights and responsibilities. To receive a copy, you can:

- Call the Customer Care Center (CCC) at the number below to ask for a copy to be mailed or faxed to you.
- Visit our website at **HealthyBlueSC.com**.

Member rights

As a member of this health plan, you have the right to:

- Observe and protect your member rights and responsibilities.
- Receive the help you need to understand this book.
- Be treated with respect and consideration for your dignity and right to privacy.
- Participate in decisions regarding your health care, including the right to refuse treatment.
- Be able to request and receive a copy of your records and request that they be amended or corrected.
- Be free from any form of restraint or seclusion used as a mean coercion, discipline, convenience, or retaliation as specified in the federal regulations on the use of restraints and seclusion.
- Get health care services that are accessible; are comparable in amount, duration, and scope to those provided under Medicaid FFS; and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- Get services that are appropriate and are not denied or reduced solely because of:
  - Diagnosis.
  - Type of illness.
  - Medical condition.
- Get health care services that are similar to those given under Healthy Connections in:
  - Length of time given.
  - Scope.
- Get health care services that do what they should be able to do for your health issue. This means your services are enough in:
  - Amount.
  - Length of time given.
  - Scope.
- Get information about the basic features of managed care so you can choose the right health plan for you. This information includes:
  - Enrollment notices.
  - Informational materials.
  - Available treatment options.
  - Alternatives in a matter and format that may be easily understood.

Customer Care Center (CCC): 866-781-5094 (TTY 866-773-9634) Mon.–Fri. 8 a.m.–6 p.m.
24-Hour Nurseline: 866-577-9710 (TTY 800-368-4424) 24 hours a day, seven days a week

  - The health plan's duties for coordinating care in a timely manner.
- Know that Healthy Blue, your doctors, and your other health care providers cannot treat you differently because of your:
  - Age.
  - Sex.
  - Race.
  - National origin.
  - Gender.
  - Gender identity.
  - Sexual preference.
  - Language needs.
  - Degree of illness or health issue.
- Have a candid discussion of appropriate or medically necessary treatment options for conditions, regardless of cost or benefit coverage.
- Get care that is medically necessary.
- Get help from the South Carolina Department of Health and Human Services (SCDHHS) and Healthy Blue in knowing what is required and covered.
- Get interpretation services free of charge for all non-English languages, not just those identified as prevalent, or if you have hearing, vision, or speech loss.
- Get health plan documents in formats such as braille, large-size print, or audio at no cost to you.
- Get all information and notices in a format that is easy to understand.
- Get information about the organization, its services, its practitioners and providers, and member rights and responsibilities.
- Obtain information from your health plan about services. This includes but is not limited to:
  - Benefits covered.
  - Procedures for obtaining benefits, including any authorization requirements.
  - Cost-sharing requirements.
  - Service area. Healthy Blue's service area is in every county statewide in South Carolina.
  - Names, locations, and phone numbers of current network providers (primary care providers (PCPs), specialists and hospital staff) who speak a language other than English.
  - Any limits on your freedom of choice among network providers.
  - Providers who are not taking new patients.
  - Benefits not offered by your health plan. Plus, how you may receive them and receive a ride to and from these services.
- Get a complete description of disenrollment rights at least annually.
- Get notice of any significant changes in the Benefits Package at least 30 days before the intended effective date of the change.
- Obtain details on emergency and after-hours coverage, including but not limited to:

  - What is an emergency medical condition, emergency services, and post-stabilization services.
  - Emergency services do not require prior authorization.
  - The process and procedures for receiving emergency services.
  - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract.
  - The fact that you have the right to use any hospital or other setting for emergency care.
  - Post-stabilization care services rules as noted in 42 CFR 422.113(c).
- Exercise these rights without adversely affecting the way Healthy Blue providers or SCDHHS treat you.
- Be notified of how to access our services.
- Be told about other treatment choices or plans for care in a way that fits your health needs.
- Know that we only cover health care services that are part of your plan.
- Refuse care from your PCP or other health care providers.
- Find out how we decide if new technology or treatment should be part of a benefit.
- Get 24-hour-a-day, seven-days-a-week access to medical advice from your PCP, either in person or by phone.
- Get news about and make an advance directive. This includes:
  - A description of state laws that apply to living wills (Chapter 66, Section 44).
  - Changes in the state law as soon as they can be given to you, but no later than 90 days after the change goes into effect.
  - The ability to change or revoke your advance directive at any time.
- Choose a provider who is part of your network. If you receive services from a provider who is not in your network or not approved by us, those services will not be covered.
- Get family planning services and supplies from a provider not in your network.
- Have problems taken care of fast. This includes things you think are wrong and issues about getting an approval from us, your coverage, or payment of services.
- Know the date you join Healthy Blue is the date your benefits begin. We will not cover services you received before this date.
- Question a decision we make about coverage for care you received from your doctor. You will not be treated differently if you make a complaint.
- Make recommendations regarding our rights and responsibilities policy.
- Tell us what you would like to change about our health plan.
- Have news about your health insurance and medical records kept private by us, your doctors, and all of your other health care providers.
- Get written documents about your plan that include information about how the plan is set up and operates.
- Get information on the grievance, appeal, and State Fair Hearing processes.
- Voice complaints or appeals about the organization or the care it provides.

- Get our rules on referrals for specialty care and other benefits not given by your PCP.
- Have your privacy guarded as noted in 45 CFR parts 160 and 164, subparts A and E (as this rule applies).
- Use your rights without being treated differently by us, the providers who contract with us or staff from SCDHHS.
- Know you will not be held liable if your health plan becomes insolvent.

Member responsibilities

As a member of this health plan, you have these responsibilities:

- Tell us and your social worker if:
  - You move.
  - You change your phone number.
  - The number of people in your household changes.
  - You have other insurance.
  - You become pregnant.
  - Your ID card is lost or stolen.
- Understand your health problems and help your doctor set treatment goals.
- Show your ID cards each time you receive medical care.
- Know the plan's procedures.
- Call us if you have questions or want to learn more.
- Make every reasonable effort to keep any agreed-upon appointments and follow-up appointments and to access preventive care services.
- Use the emergency room (ER) only for emergency services, not for routine services.
- Pay for services that are not covered by us.
- Supply information (to the extent possible) that Healthy Blue and its practitioners and providers need in order to provide care.
- Treat your PCP and other health care providers with respect.
- Follow the treatment or care that you have agreed to with your provider, or let the provider know the reasons the treatment cannot be followed, as soon as possible.
- Understand diagnosed health problems and participate in developing mutually agreed-upon treatment goals.

Part 18: Definitions

Here are some of the meanings of the terms used in this book.

Adverse benefit determination means we:

- Deny or limit the approval of a service you ask for (this includes the type or level of service).
- Reduce, delay, or end a service that was approved before.
- Deny a payment for service in whole or in part.
- Fail to provide services in a timely manner and resolve grievances and appeals in a timely manner.
- Deny a request to receive services outside your network if you live in a rural area with only one managed care organization (MCO).
- Deny a request to dispute a financial liability, including cost sharing, copays, premiums, deductibles, and coinsurance.

Advance directive (living will) means a legal document stating how you want to be treated if you cannot talk or make decisions.

Appeal means a request for review of an adverse benefit determination.

Approval by Healthy Blue means you have received an approval ahead of time from us. You may learn more about this in **Part 5: How to use your health plan** under the heading Prior authorization (an approval from Healthy Blue).

Benefits are the health care services and drugs covered under this plan.

Contracted provider means providers licensed and/or certified by the appropriate South Carolina licensing body or standard-setting agency contracted with the MCO to provide health care services.

Copays are fees some members pay for some covered services.

DAODAS means South Carolina Department of Alcohol and Other Drug Abuse Services.

Disenroll means you have to stop using the health plan because:

- You are not eligible anymore.
- You changed your health plan.

DMH means South Carolina Department of Mental Health.

Emergency medical condition means a medical condition with such severe signs (including severe pain or active labor) that a person with an average knowledge of health and medicine could reasonably believe not receiving medical care right away may:

- Place your health or the health of an unborn child at risk.
- Impair a body function.
- Cause dysfunction of a body part or organ.

Grievance means you state you are not happy about any matter other than an adverse benefit determination.

Health plan is a company that offers managed care health insurance plans.

Healthy Connections is the State Medicaid agency that brings you health care services. Healthy Connections is part of the South Carolina Department of Health and Human Services (SCDHHS).

Home health care providers give you skilled nursing care and other services at home.

Hospice gives in-home care for a member who is not expected to live for more than six months.

Hospital is a place you receive inpatient and outpatient care from doctors and nurses.

Inpatient care is when you have to stay the night in a hospital or other place for the medical care you need.

Medical doctor means a physician licensed by the Board of Medical Examiners, under the South Carolina Department of Labor, Licensing and Regulations.

Medically necessary services are those services utilized in the State Medicaid program, including quantitative and nonquantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures.

Member is a person approved by the state of South Carolina to be enrolled in our health plan.

Network means the doctors, hospitals, pharmacies, and other health care professionals or places that have entered into a professional services agreement with Healthy Blue to give services to Healthy Blue members.

Outpatient care is when you do not have to stay the night in a hospital or other place for the medical care you need.

Primary care provider (PCP) is the provider you have for most of your health care. This person helps you receive the care you need. Your PCP must approve most care ahead of time, unless it is an emergency.

Prior authorization means both Healthy Blue and your health care provider agree ahead of time that the service or care you asked for is medically necessary.

Provider means any doctor, hospital, agency, or other person who has a license or is approved to give health care services.

Here are some types of health care providers:

- **Audiologist** — a doctor who tests your hearing
- **Certified nurse-midwife** — a registered nurse licensed and certified to practice as an advanced practice registered nurse by the Board of Nursing under the South Carolina Department of Labor, Licensing and Regulations
- **Certified registered nurse anesthetist** — a nurse trained to give you anesthesia
- **Chiropractor** — a doctor who treats issues of the spine or other body parts
- **Dentist** — a doctor who takes care of your teeth and mouth
- **Family practitioner** — a doctor who treats common medical issues for people of all ages
- **General practitioner** — a doctor who treats common medical issues
- **Internist** — a doctor who takes care of adults by treating problems that have to do with the organs inside the body
- **Licensed midwife** — a person who has met the education and apprenticeship requirements established by the Department of Health and Environmental Control (DHEC)
- **Licensed professional counselor** — a person who is trained to treat behavioral and emotional problems
- **Licensed vocational nurse** — a licensed nurse who works with your doctor
- **Marriage, family, and child counselor** — a person who helps you with family problems
- **Nurse practitioner and clinical nurse specialist** — a registered nurse who completes an advanced formal education program and is licensed and certified by the Board of Nursing under the Department of Labor, Licensing and Regulations
- **Obstetrician/gynecologist (OB/GYN**) — a doctor who takes care of a woman's health (this includes when she is pregnant or giving birth)
- **Occupational therapist** — a doctor who helps you regain daily skills and activities after an illness or injury
- **Optometrist** — a doctor who takes care of your eyes and vision
- **Pediatrician** — a doctor who treats children from birth through their teen years
- **Physical therapist** — a doctor who helps you build your body's strength after an illness or injury

- **Physician assistant** — a health professional who performs such tasks as approved by the State Board of Medical Examiners in a dependent relationship with a supervising physician or under direct personal supervision of the attending physician
- **Podiatrist or chiropodist** — a doctor who takes care of your feet
- **Psychiatrist** — a doctor who treats behavioral health issues and prescribes drugs
- **Psychologist** — a person who treats behavioral health issues, but does not prescribe drugs
- **Registered nurse** — a nurse with more training than a licensed vocational nurse (LVN) and has a license to perform certain duties with your doctor
- **Respiratory therapist** — a doctor who helps you with your breathing
- **Speech pathologist** — a doctor who helps you with your speech
- **Surgeon** — a doctor who can operate on you

Reconstructive surgery is done when there is a problem with a part of your body and it is medically necessary to make that part look or work better. This problem could be caused by:

- A birth defect.
- Disease.
- Injury.

Second opinion is your right to see one more doctor to have them give their opinion about how to treat your health issue. Second opinions are available at no cost to you and may include the use of an out-of-network provider, when necessary. A second opinion from an out-of-network provider requires prior authorization. Call the Customer Care Center (CCC) if you would like to find another doctor for a second opinion.

Skilled nursing facility is a place that gives you 24-hour-a-day nursing care that only trained health professionals may give.

SCDHHS means the South Carolina Department of Health and Human Services.

Urgent medical condition is **not** an emergency, but **needs medical care** within 48 hours.

Vaccines (also called immunizations) are shots or other forms of medicine that prevent illness or disease.

Value-Added Items and Services (VAIS) means items and services provided to a Medicaid MCO member that are not included in the core benefits and are not funded by Medicaid dollars. Health care-related VAIS are items or services that are intended to maintain or improve the health status of Medicaid MCO members.

Part 19: Notice of Privacy Practices

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

OUR PRIVACY PROMISE

At Healthy Blue, we understand the importance of handling your health records with care. We are committed to protecting the privacy of your health records. State and federal laws require us to make sure that your health records are 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 health records and your legal rights with respect to our use and disclosure of your health records. 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 health records that we keep, including health records we created or received, including from private and public sources, 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) within 60 days to members who are covered under our health plan at that time. We will also post the new notice on our website at HealthyBlueSC.com.

HOW WE USE OR SHARE YOUR HEALTH RECORDS

Here are ways we may use or share your health records:

- Treatment: for example, to help your doctor provide your treatment and give you proper care.
- Payment: for example, to help us pay the bills your provider sends us.
- Health care operations: for example, to help us run our health plan and ensure that you receive quality care. We may not use or share genetic information for underwriting purposes.
- To help manage your health, we may tell your doctor about a program that could improve your health.
- To remind you about a doctor visit.
- To tell you about other treatments and programs. For example, how to stop smoking or lose weight.
- To help find ways to make our programs better.

- To help resolve a complaint filed by you or one of our doctors.

We also may share your health records with a family member, friend, or other person who is involved in your health care or payment for your health care. Before we disclose your health records to that person, we will ask you for your approval. If you are not available or unable to tell us due to illness or injury, we will decide what action is in your best interest.

State and federal law may require us to share your health records for reasons including the following:

- To state and federal agencies that manage us. For example, the South Carolina Department of Health and Human Services.
- To a public health agency. For example, to avoid a serious public health or safety threat.
- To a court of law.
- To law enforcement. For example, to help stop child abuse.
- To a coroner, medical examiner, or funeral director to help find a cause of death.
- To a medical facility for organ donor or transplant purposes.
- To government officials. For example, for national security.
- For workers' compensation.
- For disaster relief.

Federal law says we must tell you what the law says we have to do to protect PHI that is told to us, in writing or saved on a computer. We also have to tell you how we keep it safe. To protect PHI:

- On paper (called physical), we:
    - Lock our offices and files.
    - Destroy paper with health information so others cannot get it.
- Saved on a computer (called technical), we:
    - Use passwords so only the right people can get in.
    - Use special programs to watch our systems.
- Used or shared by people who work for us, doctors, or the state, we:
    - Make rules for keeping information safe (called policies and procedures).
    - Teach people who work for us to follow the rules.

WHEN WE NEED YOUR APPROVAL TO USE OR SHARE YOUR HEALTH RECORDS

Before we can use or share your health records for any reason other than one of those listed above, we must first get your written approval. If you give us approval and later decide you want to withdraw it, you can let can tell us and we will stop using or sharing your medical records for that reason.

Other than for the reasons listed above, we may not use or share your health records without your written approval. You may give us the right to share your health records with another individual for any reason. We have a form for that purpose and will send it to you upon request. You may take back your approval at any time by telling us in writing.

We must get your approval to use or disclose psychotherapy notes, except when it is required by law. We must get your approval to sell your health records to a third party. We must get your approval to send you information about health-related products or services, except those that are offered by us or associated with your health plan.

RACE, ETHNICITY, LANGUAGE, SEXUAL ORIENTATION AND GENDER IDENTIY

We get race, ethnicity, language, sexual orientation, and gender identity information about you from the state Medicaid agency and the Children's Health Insurance Program. We protect this information as described in this notice.

We use this information to:

- Make sure you get the care you need.
- Create programs to improve health outcomes.
- Create and send health education information.
- Let doctors know about your language needs.
- Provide interpretation and translation services.

We do **not** use this information to:

- Issue health insurance.
- Decide how much to charge for services.
- Determine benefits.
- Share with unapproved users.

Your personal information

Customer Care Center (CCC): 866-781-5094 (TTY 866-773-9634) Mon.–Fri. 8 a.m.–6 p.m.
24-Hour Nurseline: 866-577-9710 (TTY 800-368-4424) 24 hours a day, seven days a week

We may ask for, use, and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It is often taken for insurance reasons.

- We may use your PI to make decisions about your:
  - Health.
  - Habits.
  - Hobbies.
- We may get PI about you from other people or groups such as:
  - Doctors.
  - Hospitals.
  - Other insurance companies.

- We may share PI with people or groups outside of our company without your OK, in some cases.
- We will let you know before we do anything where we have to give you a chance to say no.
- We will tell you how to let us know if you do not want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

YOUR RIGHTS

The following are your rights with respect to your health records.

- ***You have the right to ask us to limit how we use or share your health records.*** We will try to do as you ask, but the law does not say we have to.
- ***You have the right to look at and get a paper or electronic copy of your health records that we have.*** This includes anything we use to make decisions about your health care. We will have 30 days to send it to you. If we need more time, we have to let you know.
- ***You have the right to ask us to send your information in another way or to another address.*** For instance, if you believe that you might be in danger if we mail your records to your home address, you can ask us to use another mailing address.
- ***You have the right to ask us to change your health records that we have.*** For instance, if you believe that information in your health records is missing or incorrect, you can ask us to make the changes. We will have 60 days to respond and send it to you. If we need more time, we have to let you know.
- ***You have the right to receive a list of when we have given your records to others during the past six years.*** We do not have to include any times we shared information with your approval or as allowed by law. We will have 60 days to send it to you. If we need more time, we have to let you know.
- ***You have the right to notice of breach***
  You have the right to be notified about a breach of any of your unsecured protected health information.

QUESTIONS AND COMPLAINTS

If you have a question about our privacy practices, or if you want to receive a paper copy of this notice, please call our Customer Care Center at **866-781-5094 (TTY 711)**. We are available Monday through Friday from 8 a.m. to 6 p.m. Eastern time.

If you believe we may have violated your privacy rights, you may submit a written complaint to the address below.

CONTACT INFORMATION

Attn: Privacy Official
Healthy Blue
P.O. Box 100124
Columbia, SC 29202-3124

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 health records. 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.

Customer Care Center (CCC): 866-781-5094 (TTY 866-773-9634) Mon.–Fri. 8 a.m.–6 p.m.
24-Hour Nurseline: 866-577-9710 (TTY 800-368-4424) 24 hours a day, seven days a week