Welcome to BlueCross BlueShield of South Carolina

For employees of HireRight

January 2019

SouthCarolinaBlues.com

Welcome

Take a few minutes to get to know your health plan

With benefits through BlueCross BlueShield of South Carolina, you'll find that it's good to be Blue®. You have access to top-quality care from the largest provider network in the nation.

Your BlueCross membership comes with excellent resources to help you understand your health plan and how to make the most of it. Throughout this guide, these symbols will indicate where you will find tools and information for a specific topic:

Visit our main website at **www.SouthCarolinaBlues.com**.

Go to www.SouthCarolinaBlues.com and log in to your **My Health Toolkit®** account.

Call the number on the back of your membership card to speak to a **customer service advocate**.

What do you need to do?

Download the My Health Toolkit® mobile app today! It's free at: **www.bcbs.sc/GetStarted**.

Register quickly through the app, using your member ID number. Or just log in, if you're already a My Health Toolkit user.

Your GetStarted page also will link you to all of the helpful resources included with your health benefits plan.

Now you have anywhere, anytime access to your benefits information, including claims, discounts and how you prefer to be contacted.

Rather get My Health Toolkit from a desktop/laptop computer?

Go to **www.bcbs.sc/GetStarted** and then:

- Click the **Register Now** button on the right side of the page.
- Enter your **Member ID** (from your ID card).
- Follow the instructions to **Create Your Profile**.

Helpful terms

Words commonly used in health care

Health care lingo can be confusing. But it's important to understand your health benefits and how they work. Here are some terms you might need to know.

Benefits: The items or services covered by your health insurance plan.

Claim: A request for payment that you or your health care provider submits to your health insurance company after you receive services.

Coinsurance: Your share of the costs for a covered health care service, calculated as a percentage. You pay coinsurance plus any deductibles you owe. For example, say your health plan's allowed amount for an office visit is $100 and you've met your deductible. Your coinsurance payment of 20 percent would be $20. Your health plan pays the rest of the allowed amount.

Copayment: The fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary, depending on the provider and the type of health care service.

Deductible: The amount you pay for services received before your health plan begins to pay. For example, if your deductible is $1,000, your health plan will not pay for covered services until you've paid $1,000 toward your covered health care expenses. After that, your health plan will pay for all covered services until the end of that benefit year.

Dependent: A child, spouse or other family member covered by a subscriber's health plan. For example, an employer-sponsored health plan may cover the employee (subscriber), plus the employee's spouse and their children (dependents).

Facility: The location where you receive health care services. For example, a medical facility could be a doctor's office or a hospital.

Network: The facilities, providers and suppliers your health plan contracts with to provide health care services. You will typically pay less for services received in- network versus out- of-network.

Out of pocket: These are your costs for medical care expenses that aren't reimbursed by insurance. Out- of-pocket costs include deductibles, coinsurance and copayments for covered services, plus all costs for services that aren't covered.

Subscriber: The person who enrolls in a health plan. There is only one subscriber per health plan. The subscriber can add eligible dependents to a family health plan.

Preauthorization: A decision verifying that a service, prescription drug or type of treatment is medically necessary. Certain services and medications require preauthorization before you receive them, except in an emergency. You might also hear this referred to as precertification or prior authorization.

Premium: The amount you pay for your health plan, usually biweekly or monthly.

Provider: This can refer to the medical professional who delivers care or the location where you receive health care services. For example, your provider could be a doctor, specialist, nurse practitioner or hospital.

Primary care physician (PCP): The main doctor and primary contact for your health care services. Your PCP coordinates care if you need to see other doctors or specialists.

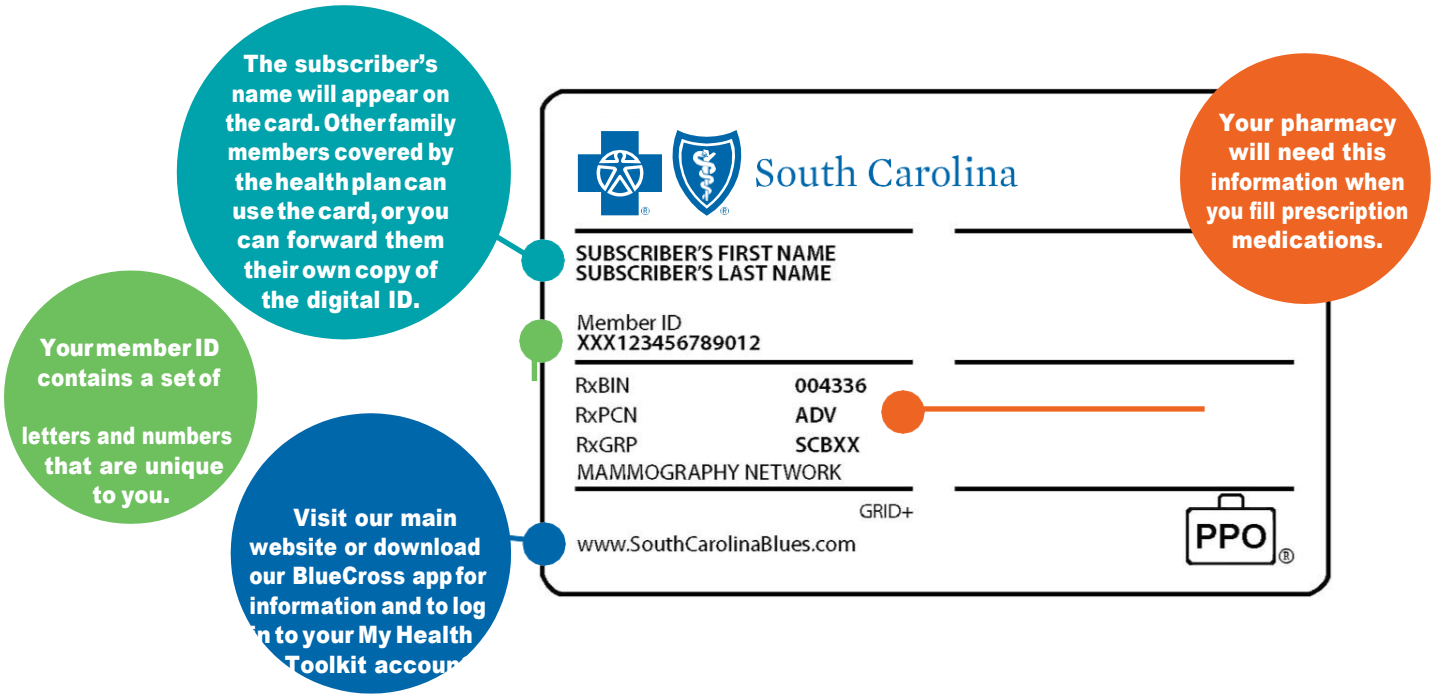
Radiology: Procedures such as X-rays, ultrasounds and magnetic resonance imaging (MRI) that are used to detect medical conditions.

Specialist: A doctor or health care professional who focuses on a specific area of medicine. For example, pediatricians, dermatologists and cardiologists are specialists.

Telehealth: Allows a patient to connect with a health care provider with virtual visits through an electronic device such as a smartphone or computer. Licensed telehealth providers offer non-emergency consultations for a variety of conditions and can prescribe medication, when appropriate.

We've got you covered with your membership card

Your BlueCross membership card contains important information that helps providers and pharmacists apply your benefits correctly. Keep it with you at all times — or download a digital ID card to keep on your smartphone. A health care provider usually will ask to see your insurance card at the beginning of your visit.



More about your digital ID card

It's all about convenience! Your digital ID card has the same information as the plastic card, but you can:

- View the digital ID on a smartphone, tablet or computer.
- Email the card to a spouse, child, doctor's office or pharmacy.
- Print the card from a smartphone, tablet or computer and use the printout just like a plastic card.

Accessing your digital ID

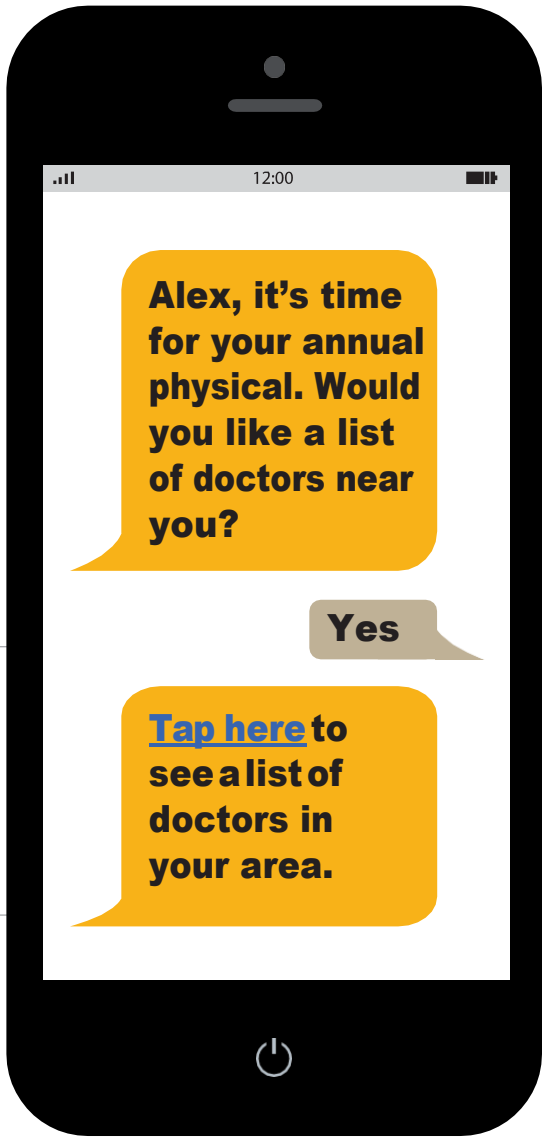
- Log in to **My Health Toolkit**.
- From a mobile device, select **Insurance Card**.
- From a computer, select **Insurance Card** and then **View Your Card**.

Member messaging provides on-the-go health info

Text messages are a great way to keep up with family, friends and appointments. They can help you stay on top of your health, too.

Are you due for a checkup? Is it time to get a flu shot? Are you interested in health and fitness discounts?

Sign up for member messaging to get cost-saving tips, health and wellness reminders and updates for your specific benefits. For example, a quick text can suggest convenient places to get a flu vaccine. It's a simple and secure way to get information you can use.



It's easy to enroll.
Call 844-206-0623 today!
Or text "Connect" to 735-29.

Where should you go when you need care?

Your primary care physician should be your first call for routine medical care. But what if your doctor's office is closed? Or it's an emergency?

Here are some general guidelines to help you choose the right type of care while saving time and money.

Doctor's Office

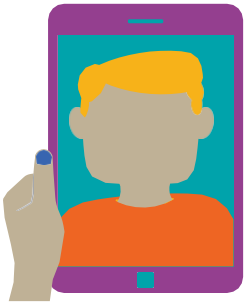
Your primary care physician, or regular doctor, is the best option for routine medical care like:

- Annual checkups, physicals
- Health screenings, immunizations
- Prescription refills

And unexpected health issues, if they can wait a day, like:

- Sprained muscles
- Minor cuts and bruises
- Cold and flu symptoms, including fever, coughing, sore throat and mild nausea
- Sinus or respiratory infections
- Urinary tract infections
- Seasonal allergies
- Pinkeye
- Migraines
- Rashes, insect bites, sunburn, other skin irritations

Blue CareOnDemand℠



If your doctor's office is closed, you're traveling or you feel too sick to drive, a Blue CareOnDemand video visit is a great option. Using your computer or mobile device, you can see a doctor who can diagnose your symptoms and call in a prescription to your local pharmacy, if needed.

Use Blue CareOnDemand for non-emergency health issues like:

- Cold and flu symptoms, including fever, coughing, sore throat and mild nausea
- Sinus or respiratory infections
- Urinary tract infections
- Seasonal allergies
- Pinkeye
- Migraines
- Rashes, insect bites, sunburn, other skin irritations

Emergency Room

Go to the ER or call 911 for potentially life-threatening conditions like:

- Heavy, uncontrolled bleeding
- Signs of a heart attack, like chest pain that lasts more than two minutes
- Signs of stroke, such as numbness, sudden loss of speech or vision
- Loss of consciousness or sudden dizziness
- Major injuries such as broken bones or head trauma
- Coughing up or vomiting blood
- Severe allergic reactions

Shopping for Care

It's easy!

Find the best health care options just like you check out your choices in cars, hotels or restaurants.

"Know before you go." It's a smart idea before you make any important decision, including finding a new doctor or choosing a location for surgery.

We make these decisions easier with Shopping for Care. It's a user-friendly tool you will find within **My Health Toolkit** on your health plan's website — or just log in via your **My Health Toolkit®** app.

Shopping for Care is exclusively for our members, and your options will match up with your benefits. Use it to:

- Find health care providers and services, based on information from our vast provider network.
- Check out cost information to make sure you're getting the care you need at the best possible price. Costs for a procedure — say, an ultrasound, MRI or joint replacement — may vary by hundreds or even thousands of dollars.
- See reviews from other patients who have rated a provider you're considering. Ratings are gleaned from a huge database of patient reviews.
- Identify Blue Distinction® Specialty Care hospitals for certain procedures — for proven results such as fewer complications.

Using the Shopping for Care tool is simple:

1. Log in to **My Health Toolkit** from your computer or mobile device.
2. Select the **Resources** tab.
3. Click **Shopping for Care**.

We'll walk you through each step.

Patient-Centered Medical Homes

A patient-centered medical home, or PCMH, is a primary care doctor's office that has met special requirements to be certified as a PCMH. The BlueCross BlueShield network has PCMH practices nationwide.

What's different about a PCMH?

In a PCMH, a dedicated team works together to provide each patient with the best possible care. For example, a patient's care team might include a primary care doctor, pharmacist, care coordinator and a dietitian. The primary care doctor will communicate closely with all team members to make sure each area provides the best support for the overall treatment plan.

Who should use a PCMH?

Anyone can choose a doctor that's part of a PCMH. The team-based approach is especially helpful for people with chronic health conditions like high blood pressure, heart failure or diabetes.

How does a PCMH benefit you?

- Care is personalized and consistent. You will see a member of your care team who knows you and your medical history.
- Results of your medical procedures are shared with members of your team. That way, they have a complete picture of your health when treating you.
- Your team can help you stay on track with care that is specific to your individual health needs.
- PCMHs offer same-day appointments for most services, and many have extended office hours on evenings and weekends. You can even talk to a clinician after hours.

To find a PCMH near you:

- Go to **www.SouthCarolinaBlues.com**.
- Select the **Live Healthy** tab.
- Click **Patient-Centered Medical Home**. The PCMH directory lists doctors' offices by county.

Or call the number on the back of your membership card to talk to a customer service advocate.

Explanation of Benefits

Be a smart health care consumer

Don't let that bill from your doctor frighten you. As our member, you have the upper hand when it comes to managing your health care costs. Before you pay a bill, take a quick look at your Explanation of Benefits, or EOB.

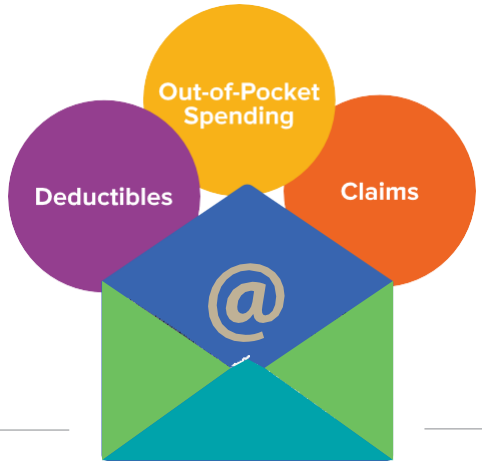
What's an EOB?

This is a report that's created whenever your health insurance processes a claim. An EOB shows you:

- How much your doctor charged for services
- How much your health plan paid
- The amount applied toward your deductible
- The amount you owe out of pocket

Why is it important to check your EOB?

The amount you pay your doctor depends on your particular health plan. But checking your EOB can help you be sure you pay the right amount. The amount the doctor or hospital is billing you should match the amount on your EOB, as long as you do not have a previous balance. Are they billing you for more than what is reflected on your EOB? If they do, review the EOB with your provider to make sure you do not pay more than you should.



View your summary EOB

- Log in to **My Health Toolkit**
- Select the **Benefits** tab
- Click **Claims Status**
- Click "View Your Summary Explanation of Benefits"

View an individual EOB for a specific service

- Log in to **My Health Toolkit**
- Select the **Benefits** tab
- Click **Claims Status**
- Search by date of service, date range or claim number
- Or select a claim from the Claims Status List

We encourage you to go paperless!

Choose paperless and we'll email you whenever a new EOB is ready to view:

- Log in to **My Health Toolkit**
- Go to **My Profile** then **My Contact Preferences**
- Set the email preference for **Your Health Insurance Claims**

Details, details

Information to make sure you're covered

Coordination of benefits

Coordination of benefits — COB, for short — affects your benefits when you or a family member also are covered under another health insurance plan. COB makes sure the right plan processes your claims first. It prevents overpayments and duplication of services. And that helps keep costs down for everyone.

What you need to do: Be sure we have up-to-date information about your other insurance. That way we can process your claims correctly and promptly.

- If you receive an Other Health Insurance Questionnaire in the mail, fill it out and return it right away. Even if you do not have coverage with another health plan, we need to know that, too.
- You also can give us this information by logging in to **My Health Toolkit**. Select the **Benefits** tab, then **Other Health Insurance**.
- Or call the number on the back of your membership card and provide the information to a customer service advocate.

We appreciate your help with this.

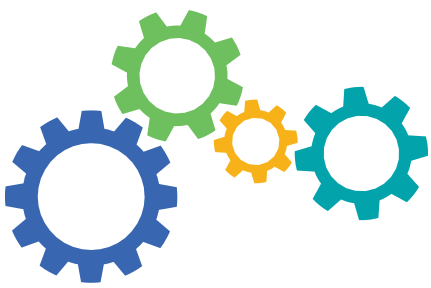
Special enrollment rights

Special enrollment rights may apply to you, your spouse or other dependents even after you have declined coverage.

- For example, you might have declined coverage because other health insurance or another group health plan was in effect. Later, you may want to seek coverage with this plan if you or your dependents became ineligible for the other coverage or the employer stops contributing to the other coverage. You must request our coverage within 30 days after this other coverage ends OR after the employer contribution stops.
- You also may be able to get coverage if you have a new dependent because of marriage, birth, adoption or placement for adoption. Again, you must request enrollment within 30 days of the event.

Please note that you may have been required to provide a written statement when you declined enrollment with us. If you did not provide this written statement, this health plan is not required to grant special enrollment rights to you or your dependents.

For more information, contact your employer's benefit department.



Member Perks

Discounts for you — just for being Blue!

In addition to superior health coverage, your membership provides access to exclusive discounts on a variety of products and services. The member discounts program includes items that are generally not covered by health insurance.

Go to **www.SouthCarolinaBlues.com** and select the **Member Discounts** tab. You'll find details on discounts for:

Fitness

- Gym memberships
- Wearable fitness devices
- Activewear
- Magazine subscriptions
- 5K and obstacle course registration
- Home fitness equipment
- Vitamins and nutritional supplements

Personal care

- Allergy relief
- Acupuncture
- Chiropractic services
- Massage therapy
- Hair restoration
- Teeth whitening

Healthy Eating

- Weight loss programs
- Cookbooks and recipes
- Online cooking classes

Hearing and Vision

- Hearing aids
- Lasik eye surgery
- Eyewear

Lifestyle

- Travel clubs
- Vacation packages
- Pet care

Prescription Drug Program

Your prescription drug plan gives you and your doctor many choices. Understanding your choices can help you make the most of your benefits and save money.

Where to find details

The drug lists for these programs are located on our website:

Go to **www.SouthCarolinaBlues.com**. Under the Helpful Links on the right, select **Prescription Drug Information**, then click **lists and programs**.

Integrated Medical and Pharmacy Benefits

With more than 68,000 network pharmacies to choose from, it's easy to find one that's near you. When you use a network pharmacy, you'll have no claim forms to file and no waiting for reimbursement. Prescription drugs under your integrated medical and pharmacy benefit may be subject to deductible and coinsurance. At network pharmacies, the pharmacist will use a computer to check your eligibility for benefits and to determine the amount you will pay for prescriptions. If you don't present your ID card or don't use a network pharmacy, you'll have to file a claim and you may not be reimbursed for the full amount you paid. Please see the benefits summary listed in this booklet to determine the amounts you pay for your prescriptions.

Specialty pharmacy

Specialty drugs treat conditions such as cancer, hepatitis, multiple sclerosis or rheumatoid arthritis, just to name a few. They often require special administration, dosing and monitoring. You may pay more for specialty drugs than non-specialty drugs for each 31-day supply. Your benefit requires you to fill specialty drugs at our preferred specialty pharmacy.

Excluded drug list

From time to time, Caremark's committee of doctors and pharmacists may decide to no longer cover some drugs when other safe, effective, less costly alternatives are available. Our list of excluded drugs also includes alternative drug options that are covered by your plan. To view this list, also called the Formulary Drug Removal list, go to our webiste and select the Education Center tab. Select Enrollment Tools then click View Drug Lists under the Caremark Performance Drug List and Related Lists section.

Mail-service program

Mail service is convenient and can save you money on prescriptions you take regularly. You'll receive up to a 90-day supply of your prescription drugs at one time with free standard shipping. To download the Prescription Drug Mail Service Form, go to our website and select the Insurance Basics tab, then Forms.

Quantity management

This program limits the amount of certain drugs your plan will cover. It's a quality and safety measure that promotes the safe use of medications.

Prior authorization

Prior authorization is a quality and safety program that promotes the proper use of certain medications. If your doctor prescribes a medication that is included in our Prior Authorization program, you must get approval before your plan will cover it. To get prior authorization, your doctor should call 800-294-5979. Or fax requests to 888-836-0730.

Step therapy

Step therapy requires you to try an alternative, cost-effective medication before trying (or "stepping up to") the more expensive brand-name medication. Many people find the alternative medications work just as well for them.

Preferred Drug List

Your prescription benefit includes a Preferred Drug List, or PDL. We want to make sure you understand the role of the PDL so you and your doctor can make the best choice for you. Here are answers to the most frequently asked questions.

What is a PDL?

A PDL is a list of prescription medications chosen for their clinical value and cost-effectiveness by an independent panel of physicians and pharmacists. Drugs on the PDL will cost you less money out of pocket than non-preferred drugs. Since there may be more than one drug available for your medical condition, we encourage you to use drugs on the PDL — generic or preferred brand-name drugs — whenever possible to help manage your prescription costs.

Where can I find the PDL?

Go to **www.SouthCarolinaBlues.com**. Under the **Helpful Links** on the right, select **Prescription Drug Information**, then click **lists and programs**.

Find a pharmacy

Log in to **My Health Toolkit** and select the **Benefits** tab. Under **Prescription Drugs**, click **Find a Pharmacy**.

How can I save money?

To save money, consider using generic or preferred brand-name drugs. If you are currently using a non-preferred drug, ask your doctor if a generic or preferred brand-name drug is appropriate for you. Generic drugs must meet the same Food and Drug Administration (FDA) quality standards as brand-name drugs. When you use a generic drug, you get the same quality as the brand-name drug – at a lower cost. NOTE: When a generic becomes available, the brand-name drug usually moves to the non-preferred drug category.

What if my drug is not listed on the PDL?

The PDL contains the most commonly prescribed drugs. If your drug is not listed, it may be that:

1. Your drug is available over the counter or is excluded from coverage. For many conditions, an over-the-counter medication may be the most appropriate treatment. Talk to your doctor about over-the-counter alternatives. They may be a good choice for you and may cost you less.
2. Your drug is not a preferred drug and is available at the highest copayment or coinsurance.

If your drug is not on the list and you have additional questions, please call the customer service number on the back of your membership card.

Prior Authorization for Specialty Medical Benefit Drugs

Your health plan requires prior authorization (PA) for most specialty drugs covered under your medical benefit. This applies to specialty drugs administered and dispensed by a medical professional.

What are specialty drugs?

Specialty drugs treat conditions such as cancer, hepatitis, multiple sclerosis or rheumatoid arthritis, just to name a few. They often require special administration, dosing and monitoring.

How are specialty drugs covered under my medical benefit?

Most specialty drugs covered under the medical benefit require prior authorization through the CVS Caremark Novologix medical prior authorization system. CVS Caremark is a division of CVS Health, an independent company that administers prior authorization services for specialty drugs billed under the medical benefit.

How do I get prior authorization under the medical benefit?

Your doctor can access the Novologix system by going to the Provider area of **www.SouthCarolinaBlues.com** and signing in to **My Insurance Manager**. Your doctor can also request prior authorization by calling **866-284-9229** or faxing **844-851-0882**.

Site of care

Prior authorization for some specialty drugs may only be granted for administration in certain locations (sites of care), such as an infusion center or in your home.

Self-administered drug block

Most specialty drugs that are typically self-administered are “blocked” from coverage under the medical benefit and are covered only under your pharmacy benefit. See the **Prescription Drug Program** section for more information on specialty drug coverage under the pharmacy benefit.

You've got a health coach in your corner

Ready to get on track with your health but not sure where to start? You don't have to figure it out on your own. Your health plan includes one-on-one coaching from a health care professional for free.

What is a health coach?

Our team of nationally accredited health coaches includes registered nurses, dietitians, health educators, respiratory therapists, certified diabetes educators, licensed behavioral health specialists and other health and well-being professionals. Wherever you are in your journey, we can connect you to the right coach. He or she will work with you to make positive, meaningful changes at your own pace.

Behavioral and chronic disease coaching

- Attention deficit hyperactivity disorder (ADHD)
- Asthma (pediatric and adult)
- Bipolar disorder
- Coronary artery disease (CAD)
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Diabetes (adult and pediatric)
- Hypertension (high blood pressure)
- Hyperlipidemia (high cholesterol)
- Metabolic health
- Migraine
- Recovery support

Wellness and healthy lifestyle coaching

- Back care
- Maternity (pregnancy and postpartum care)
- Stress management
- Tobacco-free living
- Weight management (adults and children)

Ready to become a healthier you?

To learn more and download resources, log in to **My Health Toolkit**, select the **Wellness** tab, then click **Health Coaching**.

To enroll, call the health coaching team at **855-838-5897**.

When you have questions, we'll help you get answers

The health care system can seem confusing when you're trying to get reliable information. That's why we offer Essential Advocate℠ as a free service of your health plan.

Call Essential Advocate any time of the day, any day of the week. A care coordinator will connect you with a registered nurse or other expert who can provide information, support or health pointers. For example, you can get help with:

- Concerns about medications and side effects.
- Finding a doctor, specialist or urgent care center.
- Scheduling an appointment with your doctor.
- Comparing costs before scheduling medical treatment.
- Preparing for surgery and taking steps for a healthy recovery.
- Locating helpful programs and resources in your community.

Try using Essential Advocate when you have questions. It can make navigating the health care system a little simpler.

Call toll free: 888-521-2583

Getting healthier just got easier

RALLY®

Simple changes in your daily routine can make a big difference in your health and well-being. To help, your health plan partners with Rally®, a website and mobile app that helps you set smart goals for yourself and stay on target. Rally is a product of Rally Health Inc., an independent company that offers a digital health platform on behalf of your health plan. You'll get personalized recommendations to get you moving more, eating better, feeling great — and you'll have fun doing it.

Start with a quick Health Survey. From that, you'll get your Rally Age, a measure of your overall health. Then Rally will recommend Goals and Missions for you — simple activities designed to improve your diet, fitness and mood. Other missions address important areas such as financial well-being and stress reduction. Start easy, and level up when you're ready.

Plus, there are lots of ways to earn Rally Coins, which you can use for a chance to win awesome rewards. You also can trade in your coins for significant discounts on fitness-related items. Rack up coins for participating in Missions, pushing yourself in a Challenge — even just for logging in every day. Also check out ways to use coins for auctions of products and gift cards, or to make charitable donations.

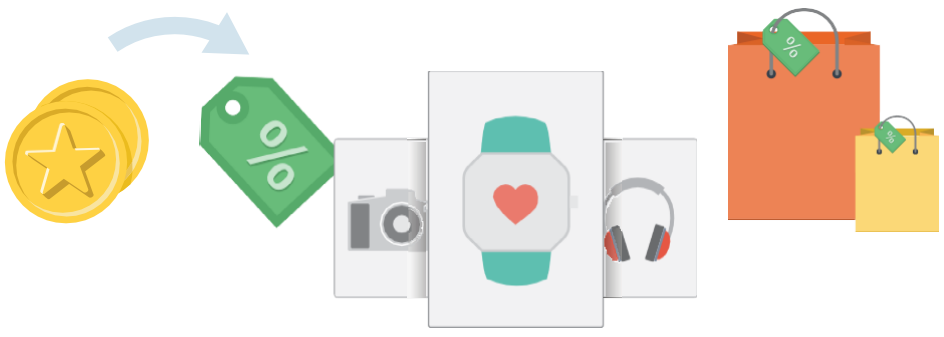
Get started today!

1. Go to **www.SouthCarolinaBlues.com**
2. Log in to your **MyHealth Toolkit®** account
3. Select **Wellness**, then **Rally**

Use Rally on the web or download the app for the convenience of Rally on the go. The Rally Health app is available in the App Store (iOS) or on Google Play (Android).

Download on the App Store

GET IT ON Google Play



Health Incentive Account

Get rewarded for making healthy choices

With a Health Incentive Account (HIA), it pays to take care of your health. This is a *free* incentive program that encourages you to take simple steps toward a healthier lifestyle. By participating, you can lower the Core Plan's annual deductible. Or, you can earn a contribution from your employer to your health savings account (HSA) (if enrolled in the 2000 or 1350 Plan).

How does it work?

Choose up to two of the activities on the next page. After you complete an activity, you will receive your incentive.

If you are enrolled in the Core Plan, you can earn a $625 credit towards the plan's deductible for each activity for a total credit of $1,250. If you spouse is enrolled in the plan, he/she can also earn $625 for each activity up to $1,250. You and your spouse must complete each activity prior to meeting the Core Plan's deductible.

If you enroll in the 2000 or 1350 Plan, for each activity you complete, you'll earn a contribution to your HSA from your employer in the amount of $200 (employer only coverage) or $400 (employee + dependent(s) coverage) for a total employer contribution of $400 or $800 respectively.

Who can participate?

If you are enrolled in the Core Plan, employees and their spouses can earn deductible credits. If you are enrolled in the 2000 or 1350 Plan, only employees are eligible to earn an employer contribution to their HSA. Dependents are not eligible.

Your activity dashboard

Visit your online dashboard to see eligible activities and track your progress.

Go to www.SouthCarolinaBlues.com and log in to **My Health Toolkit.** Select the **Wellness** tab, then select **Rally**.

Where can you see the incentives you've earned?

If you are enrolled in the Core Plan, the deductible credit(s) will appear in your summary explanation of benefits (EOB).

To view your online EOB, log in to **My Health Toolkit**. Under **Health Claims** on the main page, click **View More Health Claims**, then **View Your Summary Explanation of Benefits**.

If you are enrolled in the 2000 or 1350 Plan, you can view your employer contribution by checking your HSA balance online at www.hsabank.com. Or, by calling HSA Bank at the phone number on the back of your HSA debit card. Per your employer, your contribution will be deposited to your account generally by the end of the following month after you complete your eligible activity. For example, if you complete your health survey in April, your employer contribution will be deposited to your HSA with HSA Bank by the end of May.

How to earn your incentive

Step 1: Complete your health survey

Take a fun and interactive health survey to get your Rally age — a number that can be higher or lower than your physical age based on your lifestyle and risk factors. Rally is a product of Rally Health, Inc., an independent company that offers a digital health platform on behalf of your health plan.

To take your health survey:

- Go to **www.SouthCarolinaBlues.com**
- Log in to your **My Health Toolkit** account.
- Select the **Wellness** tab, then click **Rally**.

Step 2: Choose a second activity to complete

Option 1: Complete three missions

Improve the way you move, care, feel or eat by adding missions to your daily routine. You can choose missions as soon as you receive your Rally age. Make sure you follow the instructions to check in daily or weekly. After four weeks, your mission is complete!

Option 2: Have a wellness exam

Complete your annual physical using an in-network doctor. Women may complete an in-network routine physical or an annual gynecological exam.

Schedule your exam as far in advance as possible to ensure you receive your incentive before the end of your benefit year.

To find a doctor in your network:

- Log in to **My Health Toolkit**.
- Select the **Resources** tab.
- Select **Find a Doctor or Hospital.**

South Carolina

Preauthorization: Standard Radiology Services

Your health plan requires preauthorization for certain radiology and imaging services in an outpatient setting. If you are in the emergency room or an inpatient setting, you don't have to get preauthorization.

What services require preauthorization?

- Magnetic resonance imaging (MRI)
- Magnetic resonance angiogram (MRA)
- Computed tomography (CT) scans
- Positron emission tomography (PET) scans

What is the program designed to do?

- Promote patient safety, by preventing unnecessary radiation exposure
- Help you avoid paying unnecessary out-of-pocket expenses

What should you do?

Ask your doctor or visit **www.RadMD.com** to request authorization for the service. If your provider does not receive a preauthorization before you receive services, your health plan might not cover the treatment and you could be held liable for the payment.

What's the status of your preauthorization?

To check the status of your request for authorization:

Log in to **My Health Toolkit**, select the **Benefits** tab, then **Authorization Status**.

Or call the number on the back of your membership card to speak to a customer service advocate.

Preauthorization: Radiation Oncology Services

Your health plan requires preauthorization for certain radiation therapies used during cancer treatment. This is an extra step to make sure you receive the most appropriate treatment for your condition based on current medical guidelines.

Treatments that requirepreauthorization

These are the types of radiation treatments that require preauthorization if performed in an outpatient setting. If you don't get preauthorization before treatment, we may not cover it and the provider may bill you.

- Low-dose-rate (LDR) brachytherapy
- High-dose-rate (HDR) brachytherapy
- Two-dimensional conventional radiation therapy (2D)
- Three-dimensional conformal radiation therapy (3D-CRT)
- Intensity modulated radiation therapy (IMRT)
- Image guided radiation therapy (IGRT)
- Stereotactic radiosurgery (SRS)
- Stereotactic body radiation therapy (SBRT)
- Proton beam radiation therapy (PBT)
- Intra-operative radiation therapy (IORT)
- Neutron beam therapy
- Hyperthermia

How to submit the request

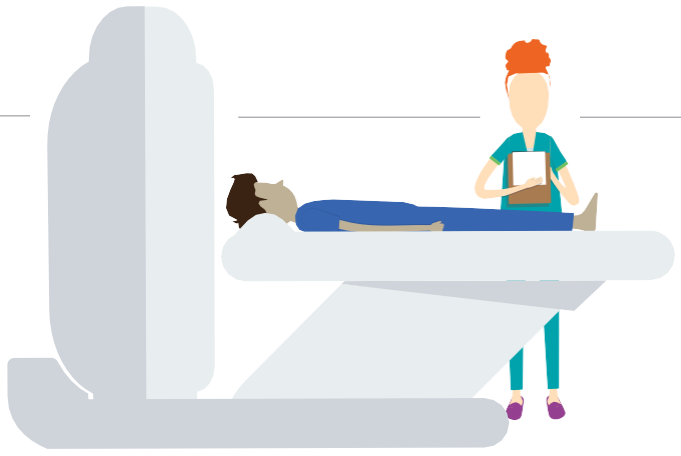
Your doctor can visit **www.RadMD.com** to complete the Radiation Therapy Treatment Form. This form can be used to request preauthorization for your entire treatment plan — it will not be required for each individual procedure.

How to check the status

If your provider does not receive a preauthorization before you receive services, your health plan might not cover the treatment and you could be held liable for the payment. Here's how you can check the status of your request.

Log in to **My Health Toolkit**, select the **Benefits** tab, then **Authorization Status**.

Or call the number on the back of your membership card to speak to a customer service advocate.



What is the program designed to do?

- Promote patient safety by preventing unnecessary radiation exposure
- Help you avoid paying unnecessary out-of-pocket expenses

Preauthorization: Musculoskeletal Care

Your health plan requires preauthorization for certain spine treatments, including surgeries and pain management services. If you are in an emergency room, preauthorization is not required.

What treatments require preauthorization?

Inpatient and outpatient surgeries:

- Lumbar microdiscectomy
- Lumbar decompression (laminotomy, laminectomy, facetectomy and foraminotomy)
- Lumbar spine fusion (arthrodesis)
- Cervical anterior decompression with fusion: Single and multiple levels
- Cervical posterior decompression with fusion: Single and multiple levels
- Cervical posterior decompression (without fusion)
- Cervical artificial disc replacement
- Cervical anterior decompression (without fusion)

Outpatient pain management services:

- Spinal epidural injections
- Paravertebral facet joint injections or blocks
- Paravertebral facet joint denervation (radiofrequency (RF) neurolysis)

What should you do?

Ask your doctor to **visit www.RadMD.com** to request authorization for treatment. If your provider does not receive a preauthorization before you receive services, your health plan might not cover the treatment and you could be held liable for the payment.

What's the status of your reauthorization?

To check the status of your authorization request:

Log in to **My Health Toolkit**, select the **Benefits** tab, then **Authorization Status**.

Or call the number on the back of your membership card to speak to a customer service advocate.

What is the program designed to do?

- Promote patient safety by preventing unnecessary surgical procedures
- Help you avoid paying unnecessary out-of-pocket expenses

Get Well Sooner

With video visits through Blue CareOnDemand℠, you can:

Visit with a doctor anytime, anywhere.

When you're not feeling well, the last thing you want to do is sit in a waiting room. With Blue CareOnDemand, you can visit with a doctor in minutes and start feeling better faster. The doctor can even send a prescription to your local pharmacy if needed.

Get treated forcommon conditions fast.

Wondering what types of conditions Blue CareOnDemand doctors can treat? Through a virtual visit, you can talk to a doctor about conditions like:

Cold and flu symptoms
Bronchitis and other respiratory infections
Pinkeye
Ear infections
Allergies
Migraines
Rashes and other skin irritations
Urinary tract infections
And more!

Visit **BlueCareOnDemandSC.com**
or download the app today.

BLUE CareOnDemand℠

Download on the App Store

ANDROID APP ON Google play

Medical Spending Accounts

To download a claim form, go to www.SouthCarolinaBlues.com. Select Insurance Basics, then File a Claim.

Health Savings Account(HSA)

An HSA is a special savings account that allows you to set aside pretax or after-tax funds for future medical and retirement expenses. You can invest these funds in your choice of stocks or mutual funds or manage the HSA like a traditional savings account. A qualified bank, financial institution or trustee can administer your HSA. You can use your HSA funds to pay your first medical expenses, including office visits, prescriptions and other health care costs. The amount you spend from the HSA for covered medical expenses counts toward your health plan deductible. Once you meet the deductible, the health plan coverage kicks in, and you are only responsible for coinsurance payments.

HSA Bank has tools that make it easy to pay your health claims

If you have a savings account with HSA Bank®, you have access to expanded services through BlueCross, which makes it easier for you to use the funds in your HSA to pay for your medical care. HSA Bank is an independent company that administers some health savings accounts on behalf of BlueCross.

On-the-spot payment options

You have access to an HSA debit card or checks to pay providers directly for medical, drug, vision, dental and other qualified expenses.

Online payment options

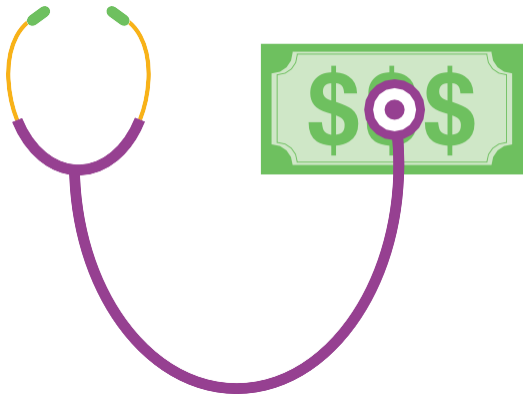
BlueCross offers two ways to pay your medical claims online with your HSA funds. To sign up, simply log in to **My Health Toolkit** and select the **Benefits** tab. Under **Financial Accounts**, click **Pay Claims with HSA Bank**.

Automatic Payment

- For maximum convenience, set up your HSA to always pay your portion of the provider's bill automatically.
- With this option, when we process your claim, we calculate what you owe and automatically send it to the provider from your HSA. If the full amount is not available in your HSA, we will make a partial payment.
- This transaction will appear online and on your Explanation of Benefits for this claim in the "CDHP Paid" column.

Claim-by-claim Payment

- This option is useful if you are saving HSA funds for a specific medical expense.
- Log in to the main page of **My Health Toolkit**. Select a processed claim from the list of recent claims. You can pay the full amount or a portion of the amount. Please note, you can only make one payment per claim from your HSA.
- You can print a payment confirmation and have a record of the transaction in My Health Toolkit.



Reimburse yourself with electronic transfer

If you pay the provider directly for your portion of the bill with non-HSA funds (such as your personal checking account), it's easy to reimburse yourself. Log in to **My Health Toolkit** and select the **Financial Info** box on the left-hand side of the page. Under **HSA Bank Account**, click **Access Account**.

Add your personal checking or savings account to your online profile first. Then transfer funds to your designated bank account whenever you need to reimburse yourself.

If you have a qualified high deductible health plan but do not have an account through HSA Bank, contact your benefits manager to learn how to open an account and begin taking advantage of these services.

Maximize the value of your medical spending account

Eligible expenses

You can use the money from your medical spending account to pay for many different services and over-the-counter items.

Eligible Health Services

Baby/child to age 13
- Lactation Consultant*
- Lead-Based Paint Removal
- Special Formula*
- Tuition: Special School/Teacher for Disability or Learning Disability*
- Well-Baby/Well-Child Care

Dental
- Dental X-Rays
- Dentures and Bridges
- Exams and Teeth Cleaning
- Extractions and Fillings
- Oral Surgery
- Orthodontia
- Periodontal Services

Eyes
- Eye Exams
- Eyeglasses and Contact Lenses
- Laser Eye Surgeries
- Prescription Sunglasses
- Radial Keratotomy

Hearing
- Hearing Aids and Batteries
- Hearing Exams

Lab exams/tests
- Blood Tests and Metabolism Tests
- Body Scans
- Cardiograms
- Laboratory Fees
- X-Rays

Medical equipment/supplies
- Air Purification Equipment*
- Arches and Orthotic Inserts
- Contraceptive Devices
- Crutches, Walkers, Wheelchairs
- Exercise Equipment*
- Hospital Beds*
- Mattresses*
- Medic Alert Bracelet or Necklace
- Nebulizers
- Orthopedic Shoes*
- Oxygen*
- Post-Mastectomy Clothing
- Prosthetics
- Syringes
- Wigs*

Medical procedures/services
- Acupuncture
- Alcohol and Drug/Substance Abuse (inpatient treatment and outpatient care)
- Ambulance
- Fertility Enhancement and Treatment*
- Hair Loss Treatment*
- Hospital Services
- Immunization
- In Vitro Fertilization*
- Physical Examination (not employment-related)
- Reconstructive Surgery (due to a congenital defect, accident or medical treatment)
- Service Animals*
- Sterilization/Sterilization Reversal
- Transplants (including organ donor)
- Transportation*

Medications
- Insulin
- Prescription Drugs

Obstetrics
- Doulas*
- Lamaze Class
- OB/GYN Exams
- OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)
- Pre- and Postnatal Treatments

Practitioners
- Allergist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Homeopath*
- Naturopath*
- Optometrist
- Osteopath
- Physician
- Psychiatrist or Psychologist

Therapy
- Alcohol and Drug Addiction*
- Counseling (not marital or career)
- Exercise Programs*
- Hypnosis
- Massage*
- Occupational
- Physical
- Tobacco Cessation Programs*
- Speech
- Weight-Loss Programs*

Note: This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are "potentially eligible expenses" that require a Note of Medical Necessity from your health care provider to qualify for reimbursement. For additional information, check your Summary Plan Document or contact your plan administrator.

Eligible expenses (continued)

Eligible Over-the-Counter Items		
• **Baby Electrolytes and Dehydration** Pedialyte, Enfalyte • **Contraceptives** Unmedicated condoms • **Denture Adhesives, Repair and Cleansers** PoliGrip, Benzodent, Plate Weld, Efferdent • **Diabetes Testing and Aids** Ascencia, One Touch, Diabetic Tussin, insulin syringes, glucose products • **Diagnostic Products** Thermometers, blood pressure monitors, cholesterol testing • **Ear Care** Unmedicated ear drops, syringes, ear wax removal	• **Elastics/Athletic Treatments** ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts • **Eye Care** Contact lens care • **Family Planning** Pregnancy and ovulation kits • **First Aid Dressings and Supplies** Band Aid, 3M Nexcare, non-sport tapes • **Foot Care Treatment** Unmedicated corn and callus treatments (e.g., callus cushions), devices, therapeutic insoles • **Glucosamine and/or Chondroitin** Osteo-Bi-Flex, Cosamin D, Flex-a-min nutritional supplements	• **Hearing Aid/Medical Batteries** • **Home Health Care (limited segments)** Ostomy, walking aids, decubitis/pressure relief, enteral/parenteral feeding supplies, patient lifting aids, orthopedic braces/ supports, splints and casts, hydrocollators, nebulizers, electrotherapy products, catheters, unmedicated wound care, wheel chairs • **Incontinence Products** Attends, Depend, GoodNites for juvenile incontinence, Prevail • **Reading Glasses and Maintenance** Accessories

Note: You may be asked to send in a receipt to verify your purchase.

Ineligible expenses

Certain expenses cannot be reimbursed by medical spending accounts, according to the IRS. Ineligible expenses typically include services and over-the-counter medications that are not prescribed by a physician.

Ineligible Health Services		
• Contact Lens or Eyeglass Insurance • Cosmetic Surgery/Procedures	• Electrolysis • Marriage or Career Counseling • Personal Trainers	• Sunscreen (SPF less than 30) • Swimming Lessons

Note: This list is not meant to be all-inclusive.

Ineligible Over-the-Counter Medications		
• Acid Controllers • Acne Medications • Allergy and Sinus • Antibiotic Products • Antifungal (foot) • Antiparasitic Treatments • Antiseptics and Wound Cleansers • Anti-diarrheals • Anti-gas • Anti-itch and Insect Bite • Baby Rash Ointments and Creams • Baby Teething Pain • Cold Sore Remedies • Contraceptives	• Cough, Cold and Flu • Denture Pain Relief • Digestive Aids • Ear Care • Eye Care • Feminine Antifungal and Anti-itch • Fiber Laxatives (bulk forming) • First Aid Burn Remedies • Foot Care Treatment • Hemorrhoidal Preps • Homeopathic Remedies • Incontinence Protection and Treatment Products • Laxatives (nonfiber)	• Medicated Nasal Sprays, Drops and Inhalers • Medicated Respiratory Treatments and Vapor Products • Motion Sickness • Oral Remedies or Treatments • Pain Relief (includes aspirin) • Prenatal Vitamins: Stuart Prenatal, Nature's Bounty Prenatal Vitamins • Skin Treatments • Sleep Aids and Sedatives • Tobacco Deterrents • Stomach Remedies • Unmedicated Nasal Sprays, Drops and Inhalers • Unmedicated Vapor Products

Note: This list is not meant to be all-inclusive. Certain medications are eligible if prescribed by a doctor in accordance with state laws. For a full list of eligible and ineligible services, please visit www.irs.gov and view Publication 502.

Adult wellness guidelines

Adult health – for ages 18 and over

Preventive care is very important for adults. By making some good basic health choices, women and men can boost their own health and well-being. Some of these positive choices include:

- Eat a healthy diet
- Get regular exercise
- Don't use tobacco products
- Limit alcohol use
- Strive for a healthy weight

Adult recommendations

Screenings	
Physical Exam	Every year, or as directed by your doctor.
Body Mass Index (BMI)	Every year.
Blood Pressure (BP)	At least every two years.
Colon Cancer Screening	Beginning at age 50 — colonoscopy every 10 years, flexible sigmoidoscopy every five years, fecal occult blood test every year or fecal immunochemical test (FIT) every year.
Diabetes Screening	Screening should begin at age 45. If you have high blood pressure, high cholesterol, are overweight or have a close family history of diabetes, you should consider being screened earlier.

Immunizations	19-21 years	22-26 years	27-49 years	50-64 years	65 and older
Influenza (Flu)*	Once each year				
Tetanus, Diphtheria, Pertussis (Tdap)*	One dose with a booster every 10 years				
Herpes Zoster (Shingles) - RZV*				Two doses RZV	
or Herpes Zoster (Shingles) - ZVL*					OR one dose ZVL for those 60 and older
Varicella (Chickenpox)*	Two doses				
Pneumococcal (Pneumonia)*					Two doses
Measles, Mumps & Rubella (MMR)*	One or two doses if no evidence of immunity				
Human Papillomavirus (HPV) – Female*	Two or three doses depending on age at series initiation				
Human Papillomavirus (HPV) – Male*	Two or three doses depending on age at series initiation				
Hepatitis A**	Two or three doses for at-risk adults. Discuss with your doctor if this vaccine is right for you.				
Hepatitis B**	Three doses for at-risk adults. Discuss with your doctor if this vaccine is right for you.				
Meningitis**	One to three doses depending on indication. This vaccine is only recommended for specific groups of adults. Discuss the risks and benefits with your doctor.				
Hib*	One to three doses depending on health risks. This vaccine is only recommended for specific groups of adults. Discuss the risks and benefits with your doctor.				

**Recommended for most adults.*
***Recommended for adults with certain health risks.*

Children's health

Put your children on the path to wellness by scheduling regular office visits with a doctor. The doctor will watch your baby's growth and progress, and should talk with you about eating and sleeping habits, safety and behavior issues.

According to the Bright Futures recommendations from the American Academy of Pediatrics, the doctor should:

- Check your child's body mass index percentile regularly beginning at age 6.
- Conduct a yearly wellness exam beginning at age 3.
- Test vision at least once between the ages of 3 and 5.

Routine Children's Immunization Schedule

Vaccine	Birth	1 mo.	2 mo.	4 mo.	6 mo.	12 mo.	15 mo.	18 mo.	1.5-3 yrs.	4-6 yrs.
Hepatitis B (HepB)	•	•			•					
Rotavirus (RV)			•	•	•*					
Diphtheria Tetanus and Pertussis (DTaP)			•	•	•		•†			•
Haemophilus Influenzae Type B (Hib)			•	•	•*	•				
Pneumococcal Conjugate (PCV)			•	•	•	•				
Inactivated Polio Vaccine (IPV)			•	•	•					•
Influenza (Flu)	• Recommended **yearly** starting at age 6 months with 2 doses given the first year.									
Measles, Mumps and Rubella (MMR)						•				•
Varicella (Chicken pox)						•				•
Hepatitis A (HepA)	• First dose: 12-23 months. • Second dose: 6-18 months later.									

• *One dose* ▫ *Range of recommended dates*

** Number of doses needed varies depending on vaccine used. Ask your doctor.*

† The fourth dose of DTaP may be given as early as 12 months, as long as at least six months have passed since the third dose.

Sources: U.S. Department of Health and Human Services, and the Centers for Disease Control and Prevention, U.S. Preventive Services Task Force

Some of these recommendations may not be covered by your health plan. Please refer to your summary of benefits to verify which services are covered.

What's on your report card?

Know your numbers.

High cholesterol, high blood pressure and being overweight are major risk factors for health conditions such as heart disease, diabetes and stroke. That's why it's so important to know your numbers.

Think of these measurements as subjects on a report card for your health. If you ignore one subject, it affects your overall grade. Focus on any areas you struggle with and make sure they receive extra attention.

Subject	Target
Body mass index (BMI)	18.5–24.9
Blood pressure	120 mm (systolic) / 80 Hg (diastolic), "120 over 80"
Total cholesterol HDL or "good cholesterol" LDL or "bad cholesterol"	Less than 200 mg/dl More than 50 for women, more than 40 for men Less than 100 for men and women
Heart rate (resting)	60-80 beats per minute (BPM)
Triglycerides	Less than 150
Fasting glucose	Less than 100 mg/dL
Waist circumference	Less than 35 inches for women, less than 40 inches for men

Sources: National Cholesterol Education Program, American Diabetes Association, National Heart, Lung and Blood Institute, and the Centers for Disease Control and Prevention.

Ask your doctor about the scores on your report card. Once you know your numbers, you can own your numbers! Work hard to improve them and minimize your risks for developing serious health conditions.

To locate a doctor in your network, log in to **My Health Toolkit**, select **Resources**, then **Find a Doctor or Hospital**.

It's not magic. It's management.

It seems like a new fad diet or miracle pill arrives every day, promising to be your skinny solution. But weight loss that lasts does not come in a bottle or occur in one magic moment.

Here's the big secret

You lose weight when you burn more calories than you eat. To manage your weight, develop an action plan that includes both physical activity and healthy eating.

Try incorporating smaller portion sizes, less fat, less sugar and more low-calorie foods into your diet. And when it comes to exercise, find activities that you enjoy and stick with them.

Just for being Blue

You have access to special rates on fitness products and programs! To learn more, visit **www.SouthCarolinaBlues.com** and select **Member Perks**. Click **Member Discounts** then **Fitness and Wellness**.

What's the status of your relationship?

Some people are extremely important in your life even though you don't get much "face time" with them. It's that way with your doctor. You probably see your doctor only a few times a year. And when you do, it's probably for minutes, not hours. Yet having a good relationship with your doctor is a key part of your health care. Here are some tips to make the most of it.

Prepare for your visit, if possible.

If it has been a while, make a list of any medications you are using. Include prescriptions, over-the-counter medications, vitamins and supplements. And make a list of any problems or symptoms you need to discuss.

Take notes.

Bring a pad and pen so you can jot down your doctor's instructions and advice. That will help you remember later.

Be honest.

Some problems might seem embarrassing to you. But they won't be to your doctor. It's best to be open and frank, providing all the details he or she may need to decide on a treatment. Ask questions about anything that's not clear.

Take care of the relationship you have with your doctor. It's another way to take care of yourself.

Everyday choices for a happy, healthy life

Wellness is more than just seeing a doctor when you are sick. It means making day-to-day decisions that can put you on the path to a long, healthy life. There are some risk factors you can't change — your age, for example, or health problems that run in the family. So it makes sense to focus on risk factors you can change.

Move

Aim for 30–60 minutes of physical activity each day. Exercise doesn't have to take place in a gym — get creative and find activities that you enjoy. Go for a walk, ride your bike, swim, jog, jump rope or even dance!

Eat

Fill half of your plate with fruits and veggies. Swap out sugary sodas with water. Choose whole grains, such as wheat, oatmeal and brown rice, instead of refined grains like white bread and white rice. Reach for lean proteins and calcium-rich foods.

Care

Take care of your body. Make sure you get enough sleep at night. Don't smoke — if you do, find the help you need to quit. Schedule your annual physical. If you notice symptoms of a health issue, don't procrastinate — see your doctor.

Feel

Get mentally fit by finding ways to de-stress. Block off some "me time" in your busy schedule. Stay connected to your friends and family. Volunteer for something you're passionate about. Read a new book or start a journal. Practice being grateful for one thing each day.

Are you taking advantage of being Blue®?

Your employer isn't just offering health insurance — they are offering Blue membership! If you're only thinking about us when you're sick, you are not taking advantage of everything that comes with your health benefits.

Log in to your health plan's website, click on Member Perks or Member Discounts and learn more about the advantages of being Blue.

Additional perks come with your health plan — at no additional cost! These resources can help you improve your health and overall well-being throughout the year.

Plan Design For: HireRight
Plan Name: Core Plan
Effective Date: January 1, 2019

The following Benefit Summary is only a brief, non-legal outline of the benefits offered.

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
MEDICAL AND SURGICAL BENEFITS		
Deductible (Embedded*)	$5,350 Individual / $10,700 Family	$6,000 Individual / $12,000 Family
Co-Insurance Shown as percentages below	$1,000 Individual / $2,000 Family	$10,000 Individual / $20,000 Family
Maximum Out of Pocket	$6,850 Individual / $13,700 Family Includes deductible, co-pays and co-insurance	$16,000 Individual / $32,000 Family Includes deductible and co-insurance
Physician Services in the Office Excluding Obstetrical Delivery, Dialysis Treatment, Chemotherapy, Radiation and Second Surgical Opinion	$25 Primary Care Co-pay, then 100% $50 Specialist Co-pay, then 100% Primary Care = General, Family Doctor, Pediatrician, Internist, OB/GYN	Deductible, 50%
Blue CareOnDemand SM	$15 Co-pay, then 100%	Not Covered
Other Physician Services Inpatient/Outpatient hospital, anesthesia services, radiology, chemotherapy, dialysis, pathology, obstetrical delivery, initial new born pediatric exam and all other outpatient/office services	Deductible, 70%	Deductible, 50%
Wellness Benefits – *Based on the Health Care Reform Guidelines refer to www.healthcare.gov* **Mammograms** – *Must see a provider in Mammography Network and follow specified age guidelines* **Pap Smear/Prostate Screening**	100% 100% 100%	Not Covered
Sustained Health Services ($300 annual maximum)	100%	Not Covered
Annual Physicals and Sustained Health Services are only covered at a Primary Care Provider.		
Inpatient Facility Charges	Deductible, 70%	$200 Co-pay, Deductible, 50%
Skilled Nursing Facility Charges (60 days per year)	Deductible, 70%	$200 Co-pay, Deductible, 50%
Outpatient Facility Charges	Deductible, 70%	Deductible, 50%
Other Services Physical/Occupational Therapy (30 combined visits) Home Healthcare Hospice	Deductible, 70%	Deductible, 50%
Chiropractic Benefits ($1,000 annual maximum)	Deductible, 70%	Deductible, 50%
Hearing Aids (2 Hearing Aids every 36 months)	Deductible, 70%	Deductible, 50%
Routine Vision Exam (1 exam every 24 months)	100%	Deductible, 50%
Ambulance	Deductible, 70%	In-Network Deductible, 70%
Emergency Room Facility Charges **	Deductible, 70%	Deductible, 50%
Emergency Room Professional Charges **	Deductible, 70%	Deductible, 50%
**Out-of-Network True Emergency Facility and Professional charges are subject to in-network coinsurance and/or co-pay and Out-of-Network Benefit Year Deductible and Out-of-pocket.		
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS		
Inpatient Facility Charges	70%	$200 Co-pay, then 50%
Inpatient Professional Charges	70%	50%
Outpatient Facility Charges	Deductible, 70%	Deductible, 50%
Outpatient Professional Charges	Deductible, 70%	Deductible, 50%
Emergency Room Facility Charges	Deductible, 70%	In-Network Deductible, 70%
Emergency Room Professional Charges	Deductible, 70%	In-Network Deductible, 70%
Physician Services in the Office	$25 Co-pay, then 100%	Deductible, 50%
PHARMACY BENEFITS		
Prescriptions *Mandatory Generic* (Includes diabetic supplies, oral contraceptives & tobacco cessation) Retail (31 day supply) Mail Order (90 day supply)	 $20 (Generic) / $40 (Preferred) / $70 (Non-Preferred) $40 (Generic) / $90 (Preferred) / $175 (Non-Preferred)	 50% after Co-pay Not Covered
Specialty Drug - Caremark Specialty Pharmacy Only 1-800-237-2767 for inquiries regarding this benefit	$125 Co-pay per 31 day supply	
BENEFIT MAXIMUMS		
Annual / Lifetime Maximum	Unlimited	

***Embedded Deductible:** An individual deductible "embedded" within the family deductible. Before the insurance benefits begin the individual must meet the embedded individual deductible amount, which is equal to the single coverage deductible.

IMPORTANT NUMBERS

Customer Service: 1-800-922-1185 (Medical) / 1-888-963-7290 (Prescription Drugs)
Pre-Authorization: 1-800-327-3238
Pre-Authorization for MRI, MRA, PET, CT & CAT scans: 1-866-500-7664
Pre-Authorization for Mental Health and Substance Abuse: 1-800-868-1032

SERVICES AND SUPPLIES THAT ARE NOT PAID FOR

Some services or supplies you receive may not be covered under this health coverage. Expenses for the following will not be paid:

- Any service or supply that is not medically necessary. However, if a service is determined to be not medically necessary because it was not rendered in the least costly setting, covered expenses will be paid in an amount equal to the amount payable had the service been rendered in the least costly setting.
- Custodial care. This is care meant simply to help people who cannot take care of themselves.
- Cosmetic or re-constructive procedures, unless following a mastectomy.
- Investigational or experimental services.
- Any treatment for surgery for obesity, weight reduction, weight control or complications there from, reversal or re-constructive procedures resulting from such treatment.
- Services or supplies related to dysfunctional conditions of the muscles of mastication, malposition, or deformities of the jawbone, orthognathic deformities or TMJ (Temporomandibular Joint Disorder including, but not limited to, surgical treatment, appliances and orthodontia.)
- Treatment resulting from acts of war or military service.
- Services you are not charged for in VA hospitals or other kinds of hospitals or agencies.
- Any service or supply provided by a member of the patient's family or by the patient, including the dispensing of drugs. A member of the patient's family means spouse, parent, grandparent, brother, sister, child or spouse's parent.
- Services or supplies you received before you had coverage under this group contract or after you no longer have this coverage.
- Luxury or convenience items and travel expenses, whether or not recommended by a physician.
- Services or supplies payable by Medicare, workers compensation or any other government or private program.
- Private duty services by sitters or companions; private duty services by RNs and LPNs unless these services are part of an approved home health or hospice program.
- Reversals of tubal ligations or vasectomies.
- Prescription drugs bought at a doctor's office, skilled nursing home, hospital or any other place that is not a pharmacy licensed to dispense drugs in the state where it is operated.
- Any service or treatment for complications resulting from any non-covered procedures.
- Any service or supply rendered to a member for diagnosis or treatment of infertility.
- Any service or supply rendered to a member for the diagnosis or treatment to change gender or to improve or restore sexual function.
- Relationship counseling, including marriage counseling, for the treatment of pre-marital, marital or relationship dysfunction.
- Services and supplies related to routine foot care.
- Food supplements, even if the supplements are ordered or prescribed by a physician.
- Prescription drugs used for weight control, obesity, cosmetic purposes, smoking cessation, hair growth or fertility.
- Any service or supply the member is not legally obligated to pay.
- Services for the removal of impacted teeth.
- Eyeglasses, contact lenses (except after cataract surgery) and examination for the prescription or fitting thereof and any hospital or physician charges related to refractive care.
- Any medical social services, occupational, visual, speech, recreational, behavioral, educational or play therapy or bio-feedback, except when part of a pre-authorized home health plan or hospice care program.
- Dental services, except for dental treatment up to 6 months after an accident.
- Services and supplies received for the treatment of any work related accident or illness.
- Durable Medical Equipment at an out-of-network provider.
- Services, supplies or treatment for varicose veins.
- Cranial Orthotics
- Hypnotism
- Pre-conception testing, pre-conception counseling or pre-conception genetic testing

SERVICES AND SUPPLIES REQUIRING PREAUTHORIZATION

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- All inpatient hospital or skilled nursing facility admissions and in-patient psychiatric
- Home health care, hospice care or inpatient physical rehabilitation
- Outpatient psychiatric care, outpatient procedures for Chemotherapy or Radiation Therapy (one time notification), Hysterectomy, Septoplasty, all Cosmetic procedures, Investigational procedures performed in outpatient or office setting, all inpatient hospital or skilled nursing facility admissions.
- Services and supplies related to human organ and tissue transplants required to use Blue Distinction Centers of Excellence.
- Benefits will be reduced or declined if required pre-authorizations are not obtained.

- To receive pre-authorization for the following procedures: computed tomography (CT), computerized axial tomography (CAT), magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA) or positron emission tomography (PET) scans. **Call 1-866-500-7664**
- Mental Health and Substance Abuse Services must be Pre-Authorized by CBA prior to services being rendered. **Call 1-800-868-1032**

NOTICE OF OUR PRIVACY POLICIES AND PRACTICES

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(06/2018)

South Carolina
BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Plan Design For: HireRight
Plan Name: 2000 Plan with HSA
Effective Date: January 1, 2019

The following Benefit Summary is only a brief, non-legal outline of the benefits offered.

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
MEDICAL AND SURGICAL BENEFITS		
Deductible	$2,000 Individual / $4,000 Family	$4,000 Individual / $8,000 Family
Co-Insurance Shown as percentages below	$4,000 Individual / $8,000 Family	$8,000 Individual / $16,000 Family
Maximum Out of Pocket (Embedded*)	$6,000 Individual / $12,000 Family Includes deductible, co-pays and co-insurance	$12,000 Individual / $24,000 Family Includes deductible and co-insurance
Physician Services in the Office	Deductible, 80%	Deductible, 60%
Blue CareOnDemand SM	Deductible, 80%	Deductible, 60%
Other Physician Services Inpatient/Outpatient hospital, anesthesia services, radiology, chemotherapy, dialysis, pathology, obstetrical delivery, initial new born pediatric exam and all other outpatient/office services	Deductible, 80%	Deductible, 60%
Wellness Benefits – *Based on the Health Care Reform Guidelines refer to www.healthcare.gov* **Mammograms** – *Must see a provider in Mammography Network and follow specified age guidelines* **Pap Smear/Prostate Screening**	100% 100% 100%	Not Covered
Sustained Health Services ($300 annual maximum)	100%	Not Covered
Annual Physicals and Sustained Health Services are only covered at a Primary Care Provider.		
Inpatient Facility Charges	Deductible, 80%	Deductible, 60%
Skilled Nursing Facility Charges (60 days per year)	Deductible, 80%	Deductible, 60%
Outpatient Facility Charges	Deductible, 80%	Deductible, 60%
Other Services Physical/Occupational Therapy (30 combined visits) Home Healthcare Hospice	Deductible, 80%	Deductible, 60%
Chiropractic Benefits ($1,000 annual maximum)	Deductible, 80%	Deductible, 60%
Hearing Aids (2 Hearing Aids every 36 months)	Deductible, 80%	Deductible, 60%
Routine Vision Exam (1 exam every 24 months)	100%	Deductible, 60%
Ambulance	Deductible, 80%	In-Network Deductible, 80%
Emergency Room Facility Charges **	Deductible, 80%	Deductible, 60%
Emergency Room Professional Charges **	Deductible, 80%	Deductible, 60%
**Out-of-Network True Emergency Facility and Professional charges are subject to in-network coinsurance and/or co-pay and Out-of-Network Benefit Year Deductible and Out-of-pocket.		
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS		
Inpatient Facility Charges	Deductible, 80%	Deductible, 60%
Inpatient Professional Charges	Deductible, 80%	Deductible, 60%
Outpatient Facility Charges	Deductible, 80%	Deductible, 60%
Outpatient Professional Charges	Deductible, 80%	Deductible, 60%
Emergency Room Facility Charges	Deductible, 80%	In-Network Deductible, 80%
Emergency Room Professional Charges	Deductible, 80%	In-Network Deductible, 80%
Physician Services in the Office	Deductible, 80%	Deductible, 60%
PHARMACY BENEFITS		
Prescriptions *Mandatory Generic* (Includes diabetic supplies, oral contraceptives & tobacco cessation) Retail (31 day supply) Mail Order (90 day supply)	Deductible, then $5 (Generic) / 80% with a minimum of $25 and a maximum of $50 (Preferred & Non-Preferred) $10 (Generic) / 80% with a minimum of $50 and a maximum of $100 (Preferred & Non-Preferred)	Not Covered
Specialty Drug - Caremark Specialty Pharmacy Only 1-800-237-2767 for inquiries regarding this benefit	Deductible, 80%	
BENEFIT MAXIMUMS		
Annual / Lifetime Maximum	Unlimited	

***Embedded Maximum Out-of-Pocket**: An Individual Maximum Out-of-Pocket "embedded" within the Family Maximum Out-of-Pocket. An Individual Maximum Out-of-Pocket amounts with any combination of Family members accumulate towards the Family Maximum Out-of-Pocket amount. No one member will exceed the Individual Maximum Out-of-Pocket.

IMPORTANT NUMBERS

Customer Service: 1-800-922-1185 (Medical) / 1-888-963-7290 (Prescription Drugs)
Pre-Authorization: 1-800-327-3238
Pre-Authorization for MRI, MRA, PET, CT & CAT scans: 1-866-500-7664
Pre-Authorization for Mental Health and Substance Abuse: 1-800-868-1032

SERVICES AND SUPPLIES THAT ARE NOT PAID FOR

Some services or supplies you receive may not be covered under this health coverage. Expenses for the following will not be paid:

- Any service or supply that is not medically necessary. However, if a service is determined to be not medically necessary because it was not rendered in the least costly setting, covered expenses will be paid in an amount equal to the amount payable had the service been rendered in the least costly setting.
- Custodial care. This is care meant simply to help people who cannot take care of themselves.
- Cosmetic or re-constructive procedures, unless following a mastectomy.
- Investigational or experimental services.
- Any treatment for surgery for obesity, weight reduction, weight control or complications there from, reversal or re-constructive procedures resulting from such treatment.
- Services or supplies related to dysfunctional conditions of the muscles of mastication, malposition, or deformities of the jawbone, orthognathic deformities or TMJ (Temporomandibular Joint Disorder including, but not limited to, surgical treatment, appliances and orthodontia.)
- Treatment resulting from acts of war or military service.
- Services you are not charged for in VA hospitals or other kinds of hospitals or agencies.
- Any service or supply provided by a member of the patient's family or by the patient, including the dispensing of drugs. A member of the patient's family means spouse, parent, grandparent, brother, sister, child or spouse's parent.
- Services or supplies you received before you had coverage under this group contract or after you no longer have this coverage.
- Luxury or convenience items and travel expenses, whether or not recommended by a physician.
- Services or supplies payable by Medicare, workers compensation or any other government or private program.
- Private duty services by sitters or companions; private duty services by RNs and LPNs unless these services are part of an approved home health or hospice program.
- Reversals of tubal ligations or vasectomies.
- Prescription drugs bought at a doctor's office, skilled nursing home, hospital or any other place that is not a pharmacy licensed to dispense drugs in the state where it is operated.
- Any service or treatment for complications resulting from any non-covered procedures.
- Any service or supply rendered to a member for diagnosis or treatment of infertility.
- Any service or supply rendered to a member for the diagnosis or treatment to change gender or to improve or restore sexual function.
- Relationship counseling, including marriage counseling, for the treatment of pre-marital, marital or relationship dysfunction.
- Services and supplies related to routine foot care.
- Food supplements, even if the supplements are ordered or prescribed by a physician.
- Prescription drugs used for weight control, obesity, cosmetic purposes, smoking cessation, hair growth or fertility.
- Any service or supply the member is not legally obligated to pay.
- Services for the removal of impacted teeth.
- Eyeglasses, contact lenses (except after cataract surgery) and examination for the prescription or fitting thereof and any hospital or physician charges related to refractive care.
- Any medical social services, occupational, visual, speech, recreational, behavioral, educational or play therapy or bio-feedback, except when part of a pre-authorized home health plan or hospice care program.
- Dental services, except for dental treatment up to 6 months after an accident.
- Services and supplies received for the treatment of any work related accident or illness.
- Durable Medical Equipment at an out-of-network provider.
- Services, supplies or treatment for varicose veins.
- Cranial Orthotics
- Hypnotism
- Pre-conception testing, pre-conception counseling or pre-conception genetic testing

SERVICES AND SUPPLIES REQUIRING PREAUTHORIZATION

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- Durable Medical Equipment over $500, network only
- All inpatient hospital or skilled nursing facility admissions and in-patient psychiatric
- Home health care, hospice care or inpatient physical rehabilitation
- Outpatient psychiatric care, outpatient procedures for Chemotherapy or Radiation Therapy (one time notification), Hysterectomy, Septoplasty, all Cosmetic procedures, Investigational procedures performed in outpatient or office setting, all inpatient hospital or skilled nursing facility admissions.
- Services and supplies related to human organ and tissue transplants required to use Blue Distinction Centers of Excellence.
- Benefits will be reduced or declined if required pre-authorizations are not obtained.

- To receive pre-authorization for the following procedures: computed tomography (CT), computerized axial tomography (CAT), magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA) or positron emission tomography (PET) scans. **Call 1-866-500-7664**
- Mental Health and Substance Abuse Services must be Pre-Authorized by CBA prior to services being rendered. **Call 1-800-868-1032**

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PRIVACY POLICIES AND PRACTICES

(06/2018)

Plan Design For: HireRight
Plan Name: 1350 Plan with HSA
Effective Date: January 1, 2019

The following Benefit Summary is only a brief, non-legal outline of the benefits offered.

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
MEDICAL AND SURGICAL BENEFITS		
Deductible	$1,350 Individual / $2,700 Family	$2,700 Individual / $5,400 Family
Co-Insurance Shown as percentages below	$1,650 Individual / $3,300 Family	$3,300 Individual / $6,600 Family
Maximum Out of Pocket (Embedded*)	$3,000 Individual / $6,000 Family Includes deductible, co-pays and co-insurance	$6,000 Individual / $12,000 Family Includes deductible and co-insurance
Physician Services in the Office	Deductible, 80%	Deductible, 60%
Blue CareOnDemand SM	Deductible, 80%	Deductible, 60%
Other Physician Services Inpatient/Outpatient hospital, anesthesia services, radiology, chemotherapy, dialysis, pathology, obstetrical delivery, initial new born pediatric exam and all other outpatient/office services	Deductible, 80%	Deductible, 60%
Wellness Benefits – *Based on the Health Care Reform Guidelines refer to www.healthcare.gov* **Mammograms** – *Must see a provider in Mammography Network and follow specified age guidelines* **Pap Smear/Prostate Screening**	100% 100% 100%	Not Covered
Sustained Health Services ($300 annual maximum)	100%	Not Covered
Annual Physicals and Sustained Health Services are only covered at a Primary Care Provider.		
Inpatient Facility Charges	Deductible, 80%	Deductible, 60%
Skilled Nursing Facility Charges (60 days per year)	Deductible, 80%	Deductible, 60%
Outpatient Facility Charges	Deductible, 80%	Deductible, 60%
Other Services Physical/Occupational Therapy (30 combined visits) Home Healthcare Hospice	Deductible, 80%	Deductible, 60%
Chiropractic Benefits ($1,000 annual maximum)	Deductible, 80%	Deductible, 60%
Hearing Aids (2 Hearing Aids every 36 months)	Deductible, 80%	Deductible, 60%
Routine Vision Exam (1 exam every 24 months)	100%	Deductible, 60%
Ambulance	Deductible, 80%	In-Network Deductible, 80%
Emergency Room Facility Charges **	Deductible, 80%	Deductible, 60%
Emergency Room Professional Charges **	Deductible, 80%	Deductible, 60%
**Out-of-Network True Emergency Facility and Professional charges are subject to in-network coinsurance and/or co-pay and Out-of-Network Benefit Year Deductible and Out-of-pocket.		
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS		
Inpatient Facility Charges	Deductible, 80%	Deductible, 60%
Inpatient Professional Charges	Deductible, 80%	Deductible, 60%
Outpatient Facility Charges	Deductible, 80%	Deductible, 60%
Outpatient Professional Charges	Deductible, 80%	Deductible, 60%
Emergency Room Facility Charges	Deductible, 80%	In-Network Deductible, 80%
Emergency Room Professional Charges	Deductible, 80%	In-Network Deductible, 80%
Physician Services in the Office	Deductible, 80%	Deductible, 60%
PHARMACY BENEFITS		
Prescriptions *Mandatory Generic* (Includes diabetic supplies, oral contraceptives & tobacco cessation) Retail (31 day supply) Mail Order (90 day supply)	Deductible, then $5 (Generic) / 80% with a minimum of $25 and a maximum of $50 (Preferred & Non-Preferred) $10 (Generic) / 80% with a minimum of $50 and a maximum of $100 (Preferred & Non-Preferred)	Not Covered
Specialty Drug - Caremark Specialty Pharmacy Only 1-800-237-2767 for inquiries regarding this benefit	Deductible, 80%	
BENEFIT MAXIMUMS		
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(06/2018)

South Carolina
BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Non-Discrimination Statement and Foreign Language Access

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

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

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

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

Si usted, o alguien a quien usted esta ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e informaci6n en su idioma sin costo alguno. Para hablar con un interprete, llame al 1-844-396-0183. (Spanish)

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, o **; mD--f!ll l** . 1-844-396-01880 {Chinese)

Neu quy vi, ho c la nglfai ma quy vi dang giup do, c6 nhfrng cau hoi quan tam ve ch*Liang* tr]nh SU'C khoe nay, quy Vise dU'Q'C giu p dCJ VO'i cac thong tin bang ngon ngCI' cua quy Vj mi n phf. De n6i chuyen VO'i m(lt thong dich Vien, xin gQi 1-844 -389-4838 {Vietnamese)

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Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa pla nong pangkalusugan g it o, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang wa lang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

EC/11,1 y Bae 1-1111-1 JlHU,a, KOTOPOMY Bbl noMoraer e, HMelOTCR sonp OCbl no noBOAY Bawero n11aHa MeAHU,HHCKoro 06CJ1y>t<1-1BaHHA, TO Bbl HMeere npaso Ha 6ecn11aTHOe no11y4eHHe nOMOW,H VI HHcj,OpMau,1-11,1 Ha pyccKOM A3bIKe. ,l].11A pa3rosopa c nepeBOA4HKOM no3BOHHTe no re11ecj)0Hy l-844-389-4840. (Russian)

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(Arabic) l-844-396-0189 -.,..i J.,..:,;jl *r-""fa* c"' - 4.,!I u.J-l w-" .J__, I

Si ou menm oswa yon moun w ap ede gen kesyon konsenan plan sante sa a, se dwa w pou resevwa asistans ak enfomasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avek yon entepret, rele nan l -844-39 8-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous etes en train d'aider, avez des questions a propos de ce plan medical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre lan gue. Pour parler a un interprete, appelez le 1-844-396-0190. (French)

Jesli Ty lub osoba, kt6rej pomagasz, macie pytania odnosnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezptatnej info rmacji i pomocy we wtasnym j zyku. Aby porozmawiac z ttumaczem, zadzwon pod numer l-844-396-0186. {Polish)

Se voce, ou alguem a quern voce esta ajudando, tern perguntas sobre este piano de saude, voce tern o direito de obter ajuda e informa ao em seu idioma e sem custos. Para falar com um interprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai ii diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un inter prete, puoi chiamare l-844-396-0184. (Italian)

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Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und lnformationen in lhrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

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Nida doodago t'aa haida bfka' ana nilwo'fgif dif Beeso Ach' h naa ' niligi haa ' ida *yi* na ' *idil* kidgo, niha'ah66t'i' nihi ka'a'doo wolgo kwii ha'at'ishH bi na' idolk:idigi doo bik'e' azlaag66. Ata ' halne'e la' bich'C ha desdzih ninizingo, koji' beesh bee h6lne' l -844-516 -6328. (Navajo)

Notes

Notes

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