Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

2025 **Member** Handbook

Last Updated: May 1, 2025

BC-07242023-M-18.12-WM-R

Table of Contents

Page Number

Welcome to Healthy Blue!

You are one of the millions of people in South Carolina who benefit from being in the family of Blue®. That's because Healthy Blue is part of BlueCross BlueShield of South Carolina. Ask your family and friends. Chances are, they are or have been happy members of a health plan from BlueCross or BlueChoice HealthPlan.

That's because there are so many benefits to being Blue. One is the local service you get when you need help. We are neighbors helping neighbors, friends helping friends and family helping family. We have close ties to the doctors and other health care providers in our network. We work together to make health care better for you. We also have a strong commitment to all the communities we serve, which includes every county in South Carolina! We support the groups and programs that help those areas thrive and improve the quality of life they offer.

We look forward to getting to know you — and helping you get to know us!

This member handbook is a great way to learn more about us and your health plan. It 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 this handbook and/or the provider directory at no charge. You can request these materials by calling Healthy Blue Customer Service.

There are other ways to learn more about us. Follow us on social media. That's an easy way to see what events we are doing in your area. You can also get helpful tips for your health and see other useful content.

Our website is also full of details. You can find this handbook and other materials that will help you use your health plan. Our secure member portal, My Health Toolkit, is also there. Be sure to set up an account for each family member with Healthy Blue and use it often. Have your ID card handy when you set up your account.

You may also want to sign up to get texts from us. It's a fast way for us to reach you. Don't worry — we only send texts when we have important news or reminders for you. You'll get more information about how to do that when you enroll in Healthy Blue.

Important Phone Numbers

IF YOU NEED TO:	PLEASE CALL:
Learn more about Healthy Blue. Use an interpreter.	**Customer Service** 866-781-5094 (TTY: 866-773-9634)
Talk to a nurse.	**24-Hour Nurseline** 800-830-1525 (TTY: 711)
Ask about your drug coverage or medicines.	**Pharmacy Customer Service** 866-781-5094 (TTY: 866-773-9634)
Find out about behavioral health or substance abuse services.	**Customer Service** **866-781-5094 (TTY: 866-773-9634)** Please dial 988 to reach the Suicide and Crisis Lifeline if you are in distress or feeling overwhelmed.
Ask about your vision coverage.	**Vision Service Plan (VSP®)** 800-877-7195 (TTY: 800-428-4833)
Ask about your dental coverage (for members under 21 years of age).	**DentaQuest** 888-307-6552
If you have hearing or speech loss and you need help speaking with non-TTY users.	**Relay South Carolina** 800-735-8583 or 711
Change your address, report changes to your health care or see what Medicaid doesn't cover.	**South Carolina Healthy Connections Medicaid** 888-549-0820 (TTY: 888-842-3620)
Ask advice about poisoning and treatment.	**National Poison Control Center** 800-222-1222
Review your choices for Medicaid plans.	**South Carolina Healthy Connections Choices** 877-552-4642 (TTY: 877-552-4670)

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

VSP is an independent company that provides vision benefits for Healthy Blue members on behalf of BlueChoice HealthPlan.

DentaQuest provides dental benefits for South Carolina Healthy Connections Medicaid.

Part 1: Extra Benefits

Before you dive into how Healthy Blue works, check out the extra benefits, services and programs we offer! Many of these "extras" you can get just for being a Healthy Blue member. Others may require you to do something first … like be active in a Healthy Blue care management program.

This list does not show everything we offer … so be sure to check out our website to see the full list. Go to www.HealthyBlueSC.com. Log in to My Health Toolkit. Choose the Extra Benefits link. You will also see how to qualify for and redeem these benefits.

For children who qualify:

- **Youth headphones for school:** Get a free over-the-ear headset. This is for members 3 to 18 years old.
- **Tutoring support:** Get a $50 gift card to use on learning support courses at www.outschool.com.* This is for members 3 to 18 years old.
- **Blue Book Club:** Get a $35 Barnes & Noble gift card to buy books for your children ages 2 years and younger.
- **Scouts BSA membership:** Get a free, annual Scouts BSA membership and a discount toward program materials. This is only at participating sites for members 7 to 18 years old.
- **Girl Scouts membership:** Get a free, annual Girl Scouts membership plus a discount toward program materials. This is only at participating sites for girls 5 to 18 years old.
- **Boys & Girls Clubs fees:** Get a $50 gift card to use towards Boys & Girls Clubs fees. This is only at participating clubs for members 6 to 18 years old.
- **Sports physical:** Get a free sports physical for members 6 to 18 years old.

For pregnant members and new parents who qualify:

- **Infant car seat:** Get a free infant car seat for your new baby. Member must be 28 weeks pregnant to 12 months postpartum to redeem.
- **Diapers for babies:** Get free cases of diapers for your baby age newborn to 15 months.

For adult members who qualify:

- **GED Ready assessment exam fee:** Get a $100 gift card to use toward GED Ready assessment fees. This is for members 17 and older.
- **Adult vision care:** Get free adult eye exams each year and glasses every two years. This is for members 21 and older.
- **Uber/Lyft transportation:** Get two $20 Uber or Lyft gift cards to use to get to job interviews. This is for members 18 years and older.

For all members:

- **Asthma and allergy relief pillow:** Get a free, hypoallergenic pillow. Member must have an asthma diagnosis within the last 12 months.
- **Blue365®:** Get discounts on health and wellness products and services.
- **Digital behavioral health care:** Members with low-level depression, anxiety or those who need help managing low-level stress can get free behavioral health support, education and coping tools digitally through our My Health Planner℠ mobile app.

*This link leads to a third-party website. This organization is solely responsible for the privacy policies and contents on its site.

Eligible members in care management*:

- **Diabetic nutritional program:** Members with an A1C greater than 8 can get dietary help. Qualified members will get:
  - Three sessions with a dietitian.
  - Three healthy grocery food box deliveries sent to their home.

- **Cardiovascular nutritional program:** Members with a cardiovascular disease can get dietary help in managing their medical condition. Qualified members will get:
  - Three sessions with a dietitian.
  - Three healthy grocery food box deliveries sent to their home.

- **Maternity nutritional program:** New moms can get dietary help with postpartum recovery. Qualified moms will get:
  - Three sessions with a dietitian.
  - Three healthy grocery food box deliveries sent to their home.

*****Members must be enrolled in the relevant care management program and complete two or more coaching calls or classes.

Part 2: How Healthy Blue Works

This handbook gives you details about how your health plan with Healthy Blue works. Take time to read each section. Here are some key points:

Healthy Blue serves members in all 46 counties in South Carolina.

Your ID cards are your keys to health care. You will get an ID card from South Carolina Healthy Connections Medicaid (your Medicaid ID card) and an ID card from Healthy Blue. You need to keep both with you and show both anytime you need care.

As a managed care plan, Healthy Blue uses a network of doctors, hospitals and other health care workers to provide your regular care. You will have a personal primary care provider (PCP) in this network. You can choose the PCP you want and change it when you want. Other Healthy Blue members in your family can choose a different PCP; you don't have to use the same one. Look at the provider directory on our website to find a PCP. You can also call Customer Service and ask us to send you the list.

Your PCP will oversee your health care and help you get the care you need. Your PCP will provide as many of your health care services as possible. Your PCP will also call us to get any approvals that may be needed for certain services. If you need care your PCP can't provide, your PCP can help you find another provider — such as a specialist — in our network.

Be sure to use doctors and hospitals in our network. If you go to someone who is not in our network, you won't be able to use your benefits to pay for your care unless it's an emergency. In an emergency, call 911 or seek care from the closest hospital to you, even if it's not in our network. You don't need approval from us.

Healthy Blue has a Comprehensive Drug List, which shows the medicines that we cover when you have a prescription from your doctor. That list is on our website. You can also call Customer Service and ask us to send you the list. We also cover over-the counter medicines like aspirin, cough syrup, and cold and flu medicine when you have a prescription for them.

Healthy Blue has many programs, services and tools to help keep you well and manage your health. You can use some of those just by going to our website. We will reach out to you about some programs, like case or chronic condition care management, when we think they are right for you. If there are other programs you think could help you, call us and let us know.

Please call Customer Service if you have any questions about Healthy Blue — our structure, how we work, our physician network or incentive plans, or our service utilization policies. We want to help you make the most of your health plan!

Part 3: How To Get Help

Help From Healthy Blue

Call Customer Service toll free at 866-781-5094 Monday through Friday from 8 a.m. to 6 p.m.
Members with hearing or speech loss may call TTY: 866-773-9634.

We are here to answer questions and learn more 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 and how to use them.
- Any limits on your benefits.
- How to get an approval for certain care.
- How to get benefits for family planning care and supplies from doctors or clinics not in your network.
- Details on family planning care and supplies you cannot get with this health plan.
- How to get specialty care and other services your PCP doesn't provide.
- What to expect if you have an emergency and how to manage your care afterward.
- How to get 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, please leave a message. We will call you back the next business day.

You also can send us a secure email using My Health Toolkit, our secure member portal. To register:

- Go to www.HealthyBlueSC.com.
- Select **My Health Toolkit**.
- Select **Register Now**.

To mail things to us, use this address:

Healthy Blue
PO Box 100317
Columbia, SC 29202-3317

You also can send us a fax at 803-870-6510.

Help in Other Languages

Healthy Blue offers you services to 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 service staff able to speak your language.
- 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 Customer Service to ask for one. Please let us know you need an interpreter at least three days (72 hours) before your visit. We are here 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 get language assistance services and translation of member materials. If you need us to translate our information, you may call Customer Service or email HBCustomerService@HealthyBlueSC.com.

Help for Members With Hearing Loss

We have 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. After our office hours and on weekends, call Relay South Carolina at 800-735-8583 or dial 711.

Help for Members With Vision Loss

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 Customer Service.

Part 4: When We Need To Hear From You

If You Move

Healthy Blue serves all counties in South Carolina. So, if you move anywhere in the state, we can still be your health plan. But if you do move, please call South Carolina Healthy Connections Medicaid at 888-549-0820 (TTY: 888-842-3620) to update your address. You can go online to apply.scdhhs.gov* to update information. You may also visit your local eligibility office to report any changes. Please also call Healthy Blue Customer Service to give us your new address so we can keep sending information about your plan.

Moving in state may mean you need to choose a new primary care provider (PCP) — one that's closer to your new home. Be sure to call us to tell us who you want your new PCP to be. We can also help you find one if you're not sure who you want.

If you move out of state, Healthy Blue will no longer be able to serve you.

If You Have Other Insurance

Please report all other insurance details to the program if:

- Your private health insurance ends.
- You get new insurance, including employer-sponsored coverage at your job.
- You have questions about your other insurance.

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

You may still be able to have Medicaid if you have other insurance. You need to report your other insurance so 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 as well.

If You Have an Accident

If you've had an accident at work or been in a car wreck, call us. You must tell us right away of a:

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

If There Are Other Changes That Affect Your Health Care

Call us if you have any other changes that could affect your health coverage. For example, let us know when you move or have other changes in your living arrangements or if the size of your family changes.

Be sure to also let South Carolina Healthy Connections Medicaid know when there's a change by calling 888-549-0820 (TTY: 888-842-3620). You can go online to apply.scdhhs.gov* to update information. You may also visit your local eligibility office.

When It's Time To Renew

Each year, South Carolina Healthy Connections Medicaid checks to see if members are still eligible for Medicaid. You will get a form in the mail when it's time to renew. Be sure to fill it out and send it back to South Carolina Healthy Connections Medicaid — even if there are no changes. If you don't return the form, you or your children will lose your South Carolina Healthy Connections Medicaid benefits and Healthy Blue won't be able to serve you.

That's why it is so important to let South Carolina Healthy Connections Medicaid know if your address changes. That way, your form will get to you at the right place and on time.

Once you get the renewal form, make sure you print clearly. Sign and date the form. Include your phone number and all necessary paperwork. Then, mail everything to:

SCDHHS Central Mail
PO Box 100101
Columbia, SC 29202-3101

You can also do this online. Go to apply.scdhhs.gov*. Select **Submit Annual Review**. Follow the steps from there. You will need to set up an account if you don't already have one.

If you need help filling out this form, please call us. We will be happy to help.

Part 5: Get Started With Healthy Blue

New to Healthy Blue? Here are some things you need to do and know.

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

Sign up for My Health Toolkit. This is the secure member portal on our website. Be sure to set up an account for each member of your family who is a Healthy Blue member.

To create an account, go to www.HealthyBlueSC.com and choose **Register Now.** You will be asked to give us some information, like your member ID number, name and date of birth. Then, you will create a username and password to use each time you log in.

Once you set up your account, you can use My Health Toolkit to:

- Request a new Healthy Blue ID card.
- Change your primary care provider (PCP).
- Send a secure email to us.
- View your Healthy Blue ID card.
- View claims we've paid and more.

You can also download the My Health Toolkit app. Find it on the App Store or Google Play. You can use the same username and password that you already created.

Make sure the PCP on your Healthy Blue ID card is the one you want. Your PCP will be your main doctor. Your PCP will approve treatment if you need it. If you want a different PCP, use My Health Toolkit or call Customer Service to let us know or help you choose one. We will send you a new ID card with the new PCP's name on it.

Call your PCP's office to set up your first doctor visit. The first meeting with your new PCP is important. You should visit your PCP within 90 days of joining Healthy Blue. To learn more about how we work with your PCP, read Part 6: How To Get Care.

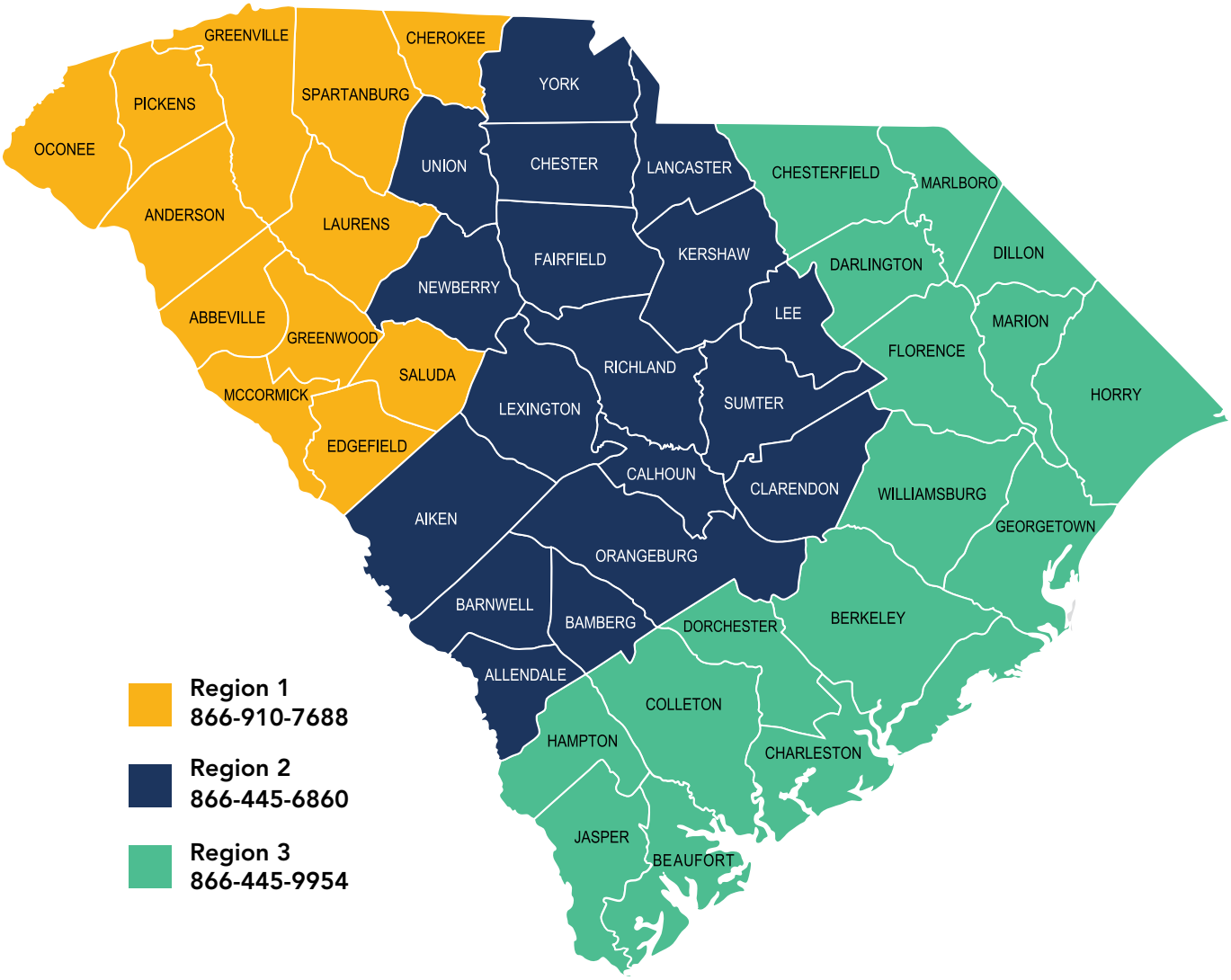
Know what to do in a true emergency. If you have an emergency, get help right away. Call 911 or go to the nearest emergency room (ER). You do not need an approval from us or your PCP to go to the ER for true emergency services.

TIP

If you are not sure what to do, you can call the 24-Hour Nurseline toll free at 800-830-1525 (TTY: 711). Have your Healthy Blue ID card ready when you call.

TIP

Need a ride to your doctor visit? South Carolina Healthy Connections Medicaid offers free, nonemergency transportation services. To get a ride, find your county in the map below. Call the phone number for rides in your region.



Part 6: How To Get Care

There are many moving parts to your health care plan. We have made it easier to understand. This section will explain how to use your health plan.

Your health care journey with Healthy Blue starts with your ID cards. Your primary care provider (PCP) will guide you on your journey, providing or helping you coordinate your care along the way. Plus, other health care professionals, like specialists, will help you when you need it. Let's get started!

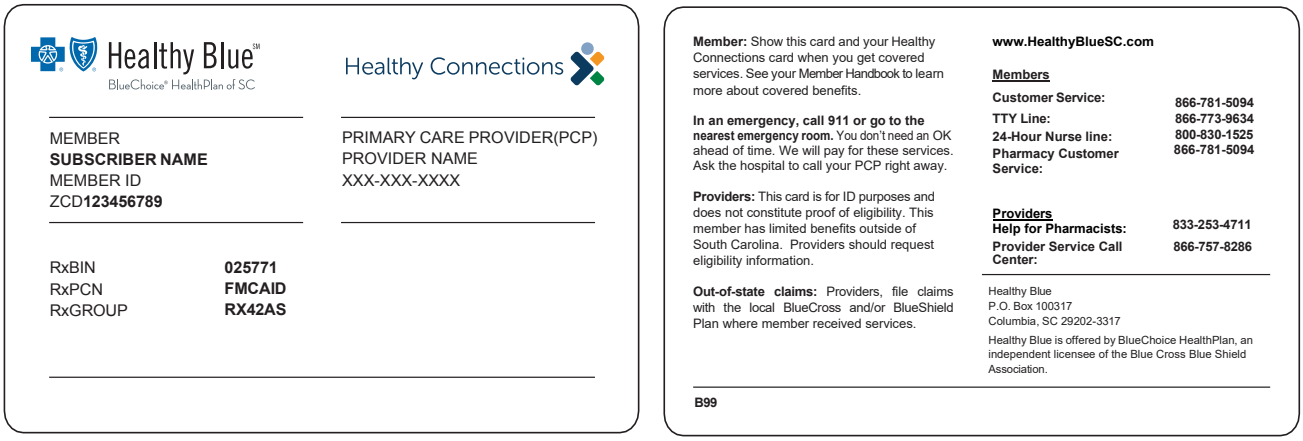
Your ID Cards

As a Healthy Blue member, you will use two ID cards to get care: your Medicaid ID card and your Healthy Blue ID card. We mail you your new Healthy Blue member ID card. You can always get a digital copy on My Health Toolkit.

South Carolina Healthy Connections Medicaid sends you your Medicaid ID card. If you have questions or need a new Medicaid ID card, call South Carolina Healthy Connections Medicaid at 888-549-0820 (TTY: 888-842-3620).

TIP
Always carry both cards with you. You'll need to show both when you get health care. South Carolina Healthy Connections Medicaid covers some services. Healthy Blue covers others. Showing both ID cards helps providers file your claim the right way.

Here's what a Healthy Blue ID card looks like:



Your ID card includes:

- Your name and member ID number.
- Your PCP's name and phone number.
- Our name, address and toll-free Customer Service phone number.
- The phone number for the 24-Hour Nurseline and Pharmacy Customer Service.
- What to do in an emergency.

You will get a new ID card if:

- You change your PCP.
- You lose your ID card and ask for a new one.

If you have not received your Healthy Blue ID card yet or if you need a new one, call Customer Service.

The member listed on the card is the only person who can use the card. If others in your home have Healthy Blue, they will each get a card from us with their name. If you let someone else use your ID card, we may not be able to keep you on our plan.

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.

Your Primary Care Provider (PCP)

A PCP is your main health care provider. Your Healthy Blue ID card will have the name of the PCP you chose or your assigned PCP if you did not choose one. **Make sure the PCP on your Healthy Blue ID card is the one you want**. If you want a different PCP, call Customer Service to let us know or help you choose one.

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 Customer Service to find out.

A PCP may be any of these types of providers:

- Pediatrician: A doctor who only 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 (OB-GYN): A doctor who only takes care of women. Women can choose an OB-GYN as their PCP, or they may see their OB-GYN without an approval from their PCP.
- Clinics, such as public health departments, Federally Qualified Health Centers (FQHCs) and rural health clinics (RHCs)

If you need to see a specialist or another kind of health care provider, your PCP can help you find one. If you need a service that requires a prior authorization from us, your PCP will handle that process for you.

Provider directory

A provider directory is a list of the providers in our network. If you need us to send you a printed provider directory or help you choose a doctor who is right for you, call us. You also can find a PCP at www.HealthyBlueSC.com.

TIP
We add new providers and hospitals to the online provider directory as soon as they join our network. You will always find the most current details online. If you do not have access to the internet, please call Customer Service. We will send you a printed copy of the provider directory at no charge.

To find the online provider directory, visit our website at www.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 imaging centers and more.
- Find out even more about a PCP or a specialist, such as the doctor's specialty, medical school, residency training or board certification.

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 provider's office hours. Look in the provider directory to find a PCP who is right for you and your family.

TIP

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

Your first visit

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.

Routine care

Your PCP will provide your routine care. Call your PCP's office to set up a doctor visit and tell them you are a Healthy Blue member. They may ask for your member ID number, so have your ID card handy.

You should be able to see your PCP within four to six weeks from the date you call. You should not have to wait more than 45 minutes for your scheduled appointment.

When you go for any doctor visit, bring your South Carolina Healthy Connections Medicaid ID card and your Healthy Blue ID card with you.

Be on time for your doctor visits. Call your PCP's office as soon as you can if you will be late. This will help shorten everyone's time in the waiting room. Plus, your PCP may not be able to see you if you are late. If so, the staff at your PCP's office will help you set up a new time.

Make sure you call your PCP if you need to change or cancel your appointment. That way, the staff can give your appointment to someone else who needs it. A PCP may refuse to keep you as a patient if you always show up late or don't show up at all without letting the office staff know.

Care when you are sick

Your PCP will care for you when you are sick. Call your PCP and tell the staff you are sick and want to see the doctor or speak to a nurse. If you need to leave a message, be sure to clearly say your name, the

phone number where you can be reached and any other requested information, such as date of birth.

What to do if your PCP's office is closed

If you call your doctor after normal office hours, listen carefully to the message you hear. It may:

- Ask you to leave your name, phone number or other information, such as date of birth.
- Tell you how to reach or be connected to an on-call doctor and get a call back within 30 minutes.

For help anytime day or night, you also may call the 24-Hour Nurseline toll free at 800-830-1525 (TTY: 711). A nurse can help you decide if you need to seek care elsewhere, such as from an urgent care facility, when your doctor's office is closed.

If you have an emergency, call 911 or your local emergency number or go to the nearest ER.

Changing your PCP

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

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 your request.
- You will get 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:

- Your current PCP is no longer in our network.
- 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 leaves the Healthy Blue network, we will mail a letter to tell you. If we know in advance that the provider is leaving the network, you will get 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.

Types of Care

There may be times when you need to see a doctor besides your PCP. Sometimes this care may require an approval from us before you get it. Be sure to read the Prior Authorization section in Part 6: How To Get Care to learn more.

Behavioral health care

This care helps you with these kinds of problems:

- Extreme stress, depression and/or anxiety
- Marriage, family and/or parenting issues
- Alcohol and drug misuse

If medically necessary, you may get:

- Inpatient mental health care.
- Mental health and/or substance use treatment.
- Outpatient mental health care and/or substance use treatment.
- Intensive outpatient treatment for mental health and/or substance use treatment.
- Partial hospitalization for substance use treatment.

We cover medically necessary services for all members who get care in a contracted hospital or South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) 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.

For outpatient services, these types of health care workers can provide covered outpatient mental health and substance use care:

- Psychiatrists
- Outpatient mental health facilities
- Psychologists
- Licensed social workers, licensed psychiatric nurses and other licensed master-level providers
- DAODAS facilities and the 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 the professionals who work there
- Rehabilitative behavioral health facilities and the professionals who work there

Please call Customer Service for help finding care, such as the name of a behavioral health specialist. If you think a behavioral health specialist doesn't meet your needs, talk to your PCP. Your PCP can help you find a different kind of specialist.

TIP

You do not need a referral from your PCP to get these services or to see a behavioral health specialist in your network. If you are having a crisis or feeling overwhelmed, please dial 988 to call the Suicide and Crisis Hotline.

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. You can also call Customer Service if you have questions about approvals and when you need them.

Urgent care

An urgent medical condition is not an emergency but needs medical care within 48 hours. If you have an urgent medical condition, call your PCP. If you need an urgent doctor visit, you will get one within 48 hours of your request.

If you cannot reach your PCP:

- Call us at 866-781-5094 (TTY: 866-773-9634).
- Call the 24-Hour Nurseline at 800-830-1525 (TTY: 711).
- Go to an urgent care facility. Use the provider directory on our website to find one near you. Or call Customer Service.

Specialist care

Your PCP may send you to a specialist for specialty care or treatment. You do not need a referral to see a specialist, but 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. Be sure to tell your PCP and the specialist as much as you can about your health, so you all can decide what is best for you.

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 the specialist you need is in our network, your PCP does not need to ask us for an approval. In-network specialists may treat you for as long as they think you need it.

If the specialist is not in our network, then your PCP must ask us to approve your visit. If you see a specialist or get specialty services from a provider out of the network before you get 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. Be sure to read Part 16: Getting Help With a Problem.

At times, our 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.

Telehealth

Be sure to ask if your PCP offers telehealth services. This lets you chat with your PCP by video on your smartphone, tablet or computer. You can share what's wrong with you or your child. Your PCP may be able to diagnose the illness or injury, tell you how to treat it, and even send a prescription to the drug store for you. This is a great option for when your PCP office is closed or you can't get to it.

24-Hour Nurseline

The 24-Hour Nurseline lets you talk in private with a registered nurse about your health anytime, day or night.

Prior Authorization

A prior authorization (PA) is an approval from Healthy Blue to get some services — before you receive them. Your PCP or specialist will ask us for this approval when one is required. This is to make sure that we cover the services before you get them.

A PA means that both Healthy Blue and your doctor agree that the services are **medically necessary**. Medically necessary services are services the state Medicaid program covers, including any treatment limits. When a service is medically necessary and 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. If urgent, it will take no more than 72 hours.

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. This letter is called an adverse benefit determination. The letter also will let you know how to appeal our decision. Read more about our appeals process in Part 16: Getting Help With a Problem.

If you have questions, you or your PCP may call Customer Service.

Here are some services that may require approval from us:

- Audiology (hearing services)
- Behavioral health and substance use disorder services
- Home health care
- Hospital inpatient services
- Long-term care
- Some labs and X-rays
- Some transportation services
- Certain prescription drugs and medicines covered under your medical benefit
- Some therapy services (physical, occupational and speech)
- Outpatient surgery

Important note

Some hospitals and providers may refuse to provide some covered services for moral or religious reasons. Some of these services include:

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

If you want these services but your provider or hospital will not perform them, call Customer Service. We will help you find a provider or hospital that will.

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 more information, we may extend the time frame to get 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 Customer Service 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. Read more about grievances in Part 16: Getting Help With a Problem.

How we decide what to cover

Healthy Blue wants to make sure our members get the medical services they need. To do so, we have to decide which services we will cover. We call this process 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 any 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:

- If the care is medically necessary
- 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.
- Approve less care than you need.
- Say you do not have coverage.

Sometimes we ask other companies that are not part of Healthy Blue to help us decide if care is proper. Some examples are those who are experts in the use of X-rays and other imaging services.

If you or your doctor has questions about our UM program, call Customer Service.

Service Reviews

Healthy Blue provides PA, continued stay and post-service reviews using clinical criteria based on evidence-based clinical guidelines and medical policies. These criteria are available to members, physicians and other health care providers upon request by contacting the UM department at 866-757-8286. Language assistance is available to help members discuss UM issues.

Continuity of care

Sometimes, we may allow members to keep getting treatment at no cost with a health care provider who is not in our network. This can happen when:

- A member is new to Healthy Blue and already getting care from a health care provider who is not in the Healthy Blue network.
- A member is getting ongoing treatment from a provider whose contract has ended with Healthy Blue for reasons that are "not for cause." These are reasons that are not related to quality of care or compliance with other contract or regulatory requirements.

When this happens, Healthy Blue will:

- Let new members get ongoing treatment from a health care provider who is not in our network for up to 90 calendar days from the date the member is enrolled in Healthy Blue.

- Let new members in the first trimester of pregnancy who are getting medically necessary covered prenatal services keep getting these services without prior approval and regardless of the provider being in or out of our network. We may move members to a network provider if doing so does not affect services. Medically necessary prenatal services include prenatal care, delivery and postnatal care.
- Allow new members in their second or third trimester of pregnancy who are getting medically necessary covered prenatal services to keep getting these services with the prenatal care provider through the postpartum period.
- Set up continuity of care for members in an active treatment program with a provider whose contract has ended with Healthy Blue.

Part 7: What Healthy Blue Covers

This section lets you see your Healthy Blue benefits. For you to get these benefits, the care must be medically necessary. Medically necessary services are those the state Medicaid program covers, including their treatment limits.

Medical and pharmacy services

As a member, you do not have copays for any services.

Dental

South Carolina Healthy Connections Medicaid provides your dental benefits through DentaQuest.

Benefit Reference Guide

Here are the benefits you can get through Healthy Blue when services are medically necessary. Keep in mind, some of these services must be approved by your PCP and/or us before you get them. You also must use a provider who is in your plan. If you get 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. Be sure to read the Prior Authorization section of Part 6: How To Get Care to learn more.

If you want to know more about what is covered, call Customer Service.

Abortions

Prior authorization: Yes

We follow all federal and state laws and rules. We will cover abortions and related services only when the doctor certifies in writing that the services are needed to save a mother's life or to end a pregnancy caused by rape or incest.

Ambulance (emergency transportation)

Prior authorization: No

We cover the use of an ambulance or air ambulance to take you to the hospital when it is medically necessary.

See also *Nonemergency transportation*.

Ancillary medical services

We cover health services your doctor orders.

See also *Independent lab and X-ray services; Therapy — physical, occupational and speech*.

Audiology (hearing) services

Prior authorization: No

For children under 21 years of age, we cover:

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

For adults 21 and over with unilateral or bilateral severe to profound sensorineural hearing loss, we cover:

- Cochlear implant placement, replacement and maintenance.

Autism spectrum disorder

Prior authorization: Yes, excluding diagnostic services.

We cover services for members under the age of 21 who have been diagnosed with autism spectrum disorder (ASD).

Behavioral health, substance use disorder services

Prior authorization: Yes

We cover inpatient and outpatient behavioral health and substance use disorder services, including:

- Acute inpatient psychiatric services.
- Community support services.

We cover one assessment per member every six months. We may approve more if medically necessary.

We also cover:

- Psychiatric diagnostic interview exams done by a doctor, a psychiatrist, a psychologist or a psychiatric nurse practitioner.
- Behavioral health services given in the ER.
- Psychiatric residential treatment facility care.
- Substance use services.
- Partial hospitalization.
- Intensive outpatient treatment services.

These services help improve daily functioning and quality of life.

If you get a bill:

Healthy Blue will pay all costs for covered services. So, in most cases, you should not get a bill from providers in our network.

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 is not in our plan, and you did not receive our approval ahead of time but asked for the service anyway.

If you get a bill and you do not think you should have to pay for the charges, call Customer Service. Have the bill with you 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.

We cover these services when given by the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS):

- 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 and intensive outpatient program
- Psychiatric diagnostic interview exams
- Group, family and individual psychotherapy
- Psychological tests
- Peer and family support
- Rehabilitative behavioral health services

See also *Smoking/tobacco cessation*.

Chiropractic services

Prior authorization: Yes

These include medically necessary services, limited to services using hands to put the bones of the spine back in line. We cover up to six visits per benefit year.

Chronic renal disease/dialysis

Prior authorization: No

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

Prior authorization: No

These services help control and stop diseases from spreading from one person to another. These can include tuberculosis (TB), sexually transmitted infections (STIs), and HIV or AIDS.

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

- Exams and reviews.
- Education 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.

Dental services

Regular Medicaid covers dental care for both children and adults. Please see Part 8: What Regular Medicaid Covers for more information.

Developmental evaluation clinic

These services are used to find and help members ages 0 to 21 who may have a delay in their development or a behavioral, learning or other health issue.

Diabetes supplies:

Prior authorization: Yes

Your pharmacy benefit and medical benefit covers:

- Blood glucose monitors, including continuous blood glucose monitors.
- Test strips.
- Lancets

Your medical benefit covers:

- One pair of diabetic shoes per year.
- Three pairs of diabetic shoe inserts per year.
- Insulin pumps for Type 1 diabetes.

Limits: We do not cover insulin pumps for Type 2 diabetes.

Durable medical equipment (DME) and disposable supplies

Prior authorization: Some items need approval from your doctor or us first.

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

- Traction equipment
- Walkers
- Surgical supplies
- Canes
- Crutches
- Ventilators
- Prosthetic devices
- Orthotic devices
- Medical products
- Oxygen
- Hearing aids and parts
- Incontinence supplies
- Diabetes supplies
- Bath safety equipment
- Nebulizers
- Wheelchairs
  - Power wheelchairs may be replaced every seven years. We do not cover wheelchair accessories, such as crutch or cane holders, umbrellas and pillows, that are not medically necessary.

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

Prior authorization: No

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

Please see Part 10: Benefits and Programs for Children for more details.

Emergency and post-stabilization services

Prior authorization: No

All emergency services are covered. You do not need an approval from us for any of these services. We also cover post-stabilization care. These are services you receive after emergency medical care to keep your condition under control. For more information, see Part 12: Urgent and Emergency Care.

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

Emergency transportation

See *Ambulance*.

Family planning

Prior authorization: No

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.
- Nontherapeutic sterilizations (tubal ligations)
- Lab services for family planning.

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

We do not cover:

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

Federally Qualified Health Center (FQHC) and rural health clinic (RHC) services

Prior authorization: No

We cover preventive care, primary care and services to help control and prevent communicable diseases.

Home health care

Prior authorization: Yes

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

- Up to 50 home health visits per calendar year.
- 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 — inpatient

Prior authorization: Yes

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.
- Operating rooms.
- Supplies.
- Medical tests and 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 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.

Hospital services — outpatient

Prior authorization: Yes

Outpatient hospital care services are services you can get at the hospital that do not require you to stay overnight.

We cover these types of services you get in an outpatient or ambulatory care setting, such as:

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

TIP
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, even if that provider is not part of the Healthy Blue network.

Hysterectomies

Prior authorization: Yes

We follow all federal and state laws and rules. We cover hysterectomies when they are nonelective and medically necessary. See Part 9: What Healthy Blue and Regular Medicaid Do Not Cover for exclusions.

Institutional long-term care facilities and nursing homes

Prior authorization: Yes

We cover the first 90 days or until you are disenrolled from our plan when you are approved for and admitted to a long-term care facility or nursing home. After the first 90 days, South Carolina Healthy Connections Medicaid will cover until you start to receive regular Medicaid.

Lab and X-ray services

Prior authorization: Some services need our 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).

We cover:

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

Limits:

- You must use a lab or facility in our network.
- Services must be medically necessary and ordered by a licensed provider.

Maternity services

To learn more about pregnancy and maternity benefits and services we offer, please read Part 11: Benefits for Pregnant Women and New Moms.

Nonemergency transportation

Prior authorization: Yes

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 prior authorization.

TIP

Transportation to other appointments may be covered by S.C. Healthy Connections Medicaid. Call the state transportation broker to learn more about these services. Use the map in Part 5 to find the phone number for your region.

TIP
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 **www.HealthyBlueSC.com**. You can also request a printed provider directory at no cost by calling Customer Service. In an emergency, go to the nearest hospital, even if it's not in our plan.

Prior authorization: No

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 drugs

Prior authorization: Some medications on the Healthy Blue Comprehensive Drug List may need a prior authorization.

Please read Part 13: How To Get Your Medicines for more information on prior authorizations and limits.

We cover:

- All prescribed drugs on the Healthy Blue Comprehensive Drug List and 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 and 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 and diaphragms.
- Drugs ordered to treat cancer if the drugs are believed to be safe and effective for the member's type of cancer.

We do not cover:

- Cosmetic or hair-growth drugs.
- Medicines from pharmacies outside of our plan.
- Drugs for erectile dysfunction.

Physical therapy

See *Therapy — physical, occupational and speech*.

Physician (doctor) services

Prior authorization: No

We cover:

- Visits to PCPs, specialists (with an approval from your PCP first, when needed) or other providers. This includes services you get from RHC or FQHC.
- Circumcision done at the hospital or doctor's office for a child up to 1 year old.
- Routine physicals — well-child visits or Early Periodic Screening Diagnosis and Treatment (EPSDT) checkups — for children through the month of their 21st birthday.
- Adult well-visit for members 21 years of age and older are covered once a year.

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

Podiatry

Prior authorization: Yes

We cover medically necessary:

- 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.

Psychiatric assessment services

See *Behavioral health, substance use disorder services*.

Rehabilitative services

Prior authorization: Some services require an approval from your PCP and/or us.

For all members with:

- Sensory, emotional, behavioral, or social impairments.
- Physical disabilities or medical conditions.
- Intellectual, developmental disabilities or delays, or other related disabilities.

For children who may have medical risk factors, we cover services where they can have their:

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

See also *Audiological services; Therapy — physical, occupational and speech*.

Members over 21 may require PA for some services.

Second opinion

It is your right to see one more doctor to have him or her give an 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. A second opinion from an out-of-network provider requires prior authorization. Call Customer Service if you would like to find another doctor for a second opinion.

Smoking/tobacco cessation

Prior authorization: No

We cover all FDA-approved medication to help you quit smoking, including:

- Bupropion for tobacco use.
- Varenicline.
- Nicotine gum, lozenge, nasal spray inhaler and patch.

We also cover:

- One-on-one telephone and web-based counseling through the Tobacco Quitline at 800-QUIT-NOW (800-784-8669).
- Counseling in individual and group settings. Limited to four sessions per quit attempt and two quit attempts per year.

Speech therapy

See *Therapy — physical, occupational and speech*.

Sterilization

The member must provide informed consent using the state's consent for sterilization form (SCDHHS Form HHS-687).

We follow all federal and state laws and rules. We do not cover:

- Surgery to reverse sterilization.
- Hysterectomy for sterilization.

Substance use treatment

See *Behavioral health, substance use disorder services*.

Therapy — physical, occupational and speech

Prior authorization: Some 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 combined hours or 420 units per benefit year.

We may approve more visits, hours or units if medically necessary.

Transplant and transplant related services

Healthy Blue covers transplant services for all members based on medical necessity.

Covered transplant services fall into two groups:

Group I: Includes corneal and kidney transplants for which coverage is applicable in all medically necessary instances without restriction and without prior approval.

Group II: Prior authorization: Yes

Includes pancreas, bone marrow, heart, liver, liver with small bowels and lung transplants when medically necessary and clinically acceptable. Coverage of these transplants is limited to facilities within the geographic boundaries of South Carolina. All authorization requests for pancreas, bone marrow, heart, liver, liver with small bowel and lung transplants will be evaluated utilizing uniform professional and administrative guidelines as to medical necessity.

Vaccines

Prior authorization: No

We cover all FDA-approved, Advisory Committee on Immunization Practices (ACIP)-recommended vaccines for adults and children. Learn more about vaccines in Part 14: Keeping Your Family Well.

Vision services

Prior authorization: No

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:

- 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 www.HealthyBlueSC.com or on the VSP website at www.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.

Well-child visits

See *Early and Periodic Screening, Diagnosis and Treatment (EPSDT)*.

Well-woman Visits

Prior authorization: No

Female members may receive routine and preventive care from a women's health specialist, such as an OB-GYN. You do not need a referral or approval.

Part 8: What Regular Medicaid Covers

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

Here are some services regular Medicaid covers.

Dental services

For children under 21 years of age, this includes:

- Routine dental care.
- Oral exams.
- Cleanings.
- X-rays.
- Fluoride treatments.
- Diagnostic, preventive restorative and surgical benefits.

For members 21 and older, benefits include:

- 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.

DentaQuest provides dental benefits of behalf of regular Medicaid. Call DentaQuest toll free at 888-307-6552 to learn more.

Long-term care

These are services such as:

- 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 reenrolled in regular Medicaid.
- Home-based care.

Medicaid Adolescent Pregnancy Prevention Services (MAPPS)

MAPPS are designed to prevent teenage pregnancy among at-risk youths, promote abstinence and educate youth to make responsible decisions about sexual activity. These services are provided in schools, office setting, homes and other approved settings.

Targeted case management

These are services that help you get access to medical, social, educational and other services you may need.

Healthy Blue provides referral assistance to members for targeted case management services:

- Individuals with intellectual and related disabilities
- At-risk children
- Adults with serious and persistent mental illness
- At-risk pregnant women and infants
- Adults with functional impairments
- Individuals with psychoactive substance disorders
- Individuals at risk for genetic disorders
- Individuals with head and spinal cord injuries and related disabilities
- Individuals with sensory impairments

Other benefits covered by regular Medicaid include:

- Care from groups in the area where you live.
- Head injury rehab care.
- Home and community-based services waiver.
- Intermediate care settings for individuals with intellectual disabilities.
- Transport not for an emergency.
- State institution services.
- Services given by community developmental disability organizations.
- School-based services.
- Hospice care.

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 9: What Healthy Blue and Regular Medicaid Do Not Cover

Some benefits and services Healthy Blue and regular Medicaid do not cover include:

- 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, and 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 or 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) or 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.
- Drugs that are not approved by the U.S. Food and Drug Administration (FDA).
- 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 get outside the U.S.
- Services for your personal care, like help with dressing, feeding and making food. Please note these services may be available in special circumstances but may require prior authorization.
- Services and procedures related to gender transition.

Part 10: Benefits and Programs for Children

Be sure to read Part 7 and Part 8 to see the full list of what Healthy Blue and regular Medicaid cover. But here are some of the key benefits and special programs you may need for your children.

TIP
Be sure your child goes to all recommended doctor visits and gets shots at the appropriate ages!

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

This program provides well-child care to children through the month of their 21st birthday. A well-baby and well-child visit may include a full-body exam, vaccines, and other tests and screenings needed based on your child's age. Be sure to read Part 14: Keeping Your Family Well to see what screenings and shots your child needs.

Dental care

South Carolina Healthy Connections Medicaid provides dental benefits as a regular Medicaid benefit. Members under 21 years can receive routine dental care, including oral exams, cleanings and X-rays; fluoride treatments; and diagnostic, preventive, restorative and surgical benefits.

Hearing services

Healthy Blue covers hearing exams and screenings, preventive and corrective services, ear molds, and hearing aids and supplies for children ages 0 through 20 years (through the last day of the month of the 21st birthday).

Therapy

Healthy Blue covers speech, occupational and therapy services.

Vision care

For members 21 years of age and older, Healthy Blue covers:

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

Part 11: Benefits for Pregnant Women and New Moms

Be sure to read Part 7 and Part 8 to see the full list of what Healthy Blue and regular Medicaid cover. But here are some of the key benefits and special programs for pregnant women and new moms — plus extra information to help you have a healthy pregnancy.

TIP
Be sure to schedule and go to all your recommended prenatal and post-partum visits!

Benefits for Pregnant Members

Your Healthy Blue benefits 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 in-network nurse-midwife.
- Up to three ultrasounds.
- Tests you need, like HIV tests, treatment and counseling. A pregnant member may choose not to take an HIV test.
- In-network birthing center services.
- 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 for children 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 you and your baby 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.

Special Programs for Pregnant Members

Healthy Blue's Maternity Management Program

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

- Access to My Health Planner℠.
- 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 through the 24-Hour Nurseline.
- 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.

Once your baby is here, we will send you information on:

- How to get 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.

CenteringPregnancy

CenteringPregnancy is prenatal care that members ages 12 to 55 can get in a group setting. It gives you more time with your doctor and other expectant moms. During these visits, you can talk about your pregnancy and infant health with clinical supervision and support.

We will cover up to 10 visits before your baby is born as long as the visits last at least 1.5 hours and have between two and 20 people in the group.

To find approved sites in South Carolina, go to www.CenteringHealthcare.org*. Select Locations and use the map to choose South Carolina.

Women, Infants and Children (WIC)

WIC gives healthy food to pregnant women 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 or visit your local health department. You can find your local health department at https://dph.sc.gov/.

Now that you know what Healthy Blue offers, you should know what to do when you learn you are pregnant:

Call Customer Service right away. We 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.

Call your doctor. If you are in your first three months of pregnancy, ask to have your first prenatal care visit within 14 days. If you are in your fourth, fifth or sixth month of pregnancy, ask for a visit within seven days. If you are in later months of your pregnancy (seventh, eighth or ninth month), ask to be seen within three business days.

If you think you have a high-risk pregnancy, ask to be seen right away. High risk means that, due to 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.

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

Stop smoking and using other harmful substances. Healthy Blue covers drugs prescribed by a Medicaid provider and approved by the FDA at no cost to you. You can also get help from the Tobacco Quitline at 800-QUIT-NOW (800-784-8669).

Get prenatal care

Within the first three months of pregnancy, see your doctor to set up a prenatal care plan. At each visit, your doctor will check your health and the health of your baby. The doctor may talk to you about:

- What to eat.
- How to be active when pregnant.
- Avoiding tobacco, drugs, alcohol and other substances.
- Breastfeeding, lactation supplies and counseling.

Tests and screenings

Based on your past health, your doctor may want you to have these screenings:

- Depression screenings (done during and after pregnancy)
- Diabetes
- Preeclampsia* (high blood pressure that causes other problems during pregnancy)
- Hematocrit/hemoglobin (blood count)
- Rubella immunity to find out if you need the rubella, aka German measles, vaccine after giving birth
- Rh(D) blood type and antibody testing to see if your blood type and your baby's blood type are compatible
  - If Rh(D) negative, repeat test at 24 to 28 weeks.
- Hepatitis B
- HIV
- Syphilis
- Urine for asymptomatic bacteriuria, as your doctor suggests

Other tests and screenings you may need:

- Amniocentesis, an ultrasound and testing of the fluid surrounding your baby
- Cell-free DNA, a blood test to check for chromosomal abnormalities in the baby
- Chorionic villus sampling to check for birth defects and more
- Ultrasound tests to look at the baby in the womb
  - During the first three months, these are done along with blood tests to check the baby for chromosomal abnormality risk and more.

These and other tests can check the baby for health concerns. The right tests and the right times to do them depend on your age and your medical history and family history. Talk to your doctor about which tests may be best for you and any risks they may have. Also ask what those tests can tell you about your baby.

Vaccines

It's best to get most vaccines before pregnancy. Check with your doctor to make sure you are up to date on your vaccines.

Flu: If you are pregnant during flu season (October through March), your doctor may want you to have the inactivated, or killed, flu shot.

RSV: Talk to your doctor about getting this vaccine while you are pregnant to help prevent severe RSV disease in your baby. For pregnant women, this is typically recommended during weeks 32 through 36 of pregnancy during September through January.

Tdap: Pregnant teens and adults need a Tdap vaccine during each pregnancy. It's best to get the vaccine between weeks 27 and 36, although it may be given at any time during pregnancy.

*If you have a high risk of preeclampsia, your doctor may recommend taking a low-dose aspirin to prevent other problems while you are pregnant.

You should NOT receive these vaccines while you are pregnant:

- Measles, mumps and rubella (MMR)
- Varicella (chickenpox)

After Your Baby Is Born

South Carolina Healthy Connections Choices will enroll your baby on the same plan you have the month your baby is born. You may choose to enroll your baby in another plan within 90 days of enrollment. Call South Carolina Healthy Connections Choices at 877-552-4642 (TTY: 877-552-4670).

Call Healthy Blue Customer Service to tell us the name of the PCP you want for your baby, if you have not already done so. If you do not choose a PCP for your baby, we will choose one for you.

Planning for the Future

Having another baby may not be on your mind so soon after you have a baby. But it's never too soon to think about family planning.

Family planning can help teach you how to:

- Be as healthy as you can be before you become pregnant again.
- Keep you from becoming pregnant if you're not ready to have another baby.
- Keep you from getting an STI or STD.

You may see any family planning Medicaid provider without getting an approval from us first. To learn more about your family planning benefit, see Part 7: What Healthy Blue Covers.

Part 12: Urgent and Emergency Care

What Is Urgent Care?

An urgent medical condition is not an emergency but needs medical care within 48 hours. If you have an urgent medical condition, call your primary care provider (PCP). If you need an urgent doctor visit, you will receive one within 48 hours of your request.

If you cannot reach your PCP:

- Call us at 866-781-5094 (TTY: 866-773-9634).
- Call the 24-Hour Nurseline at 800-830-1525 (TTY: 711).
- Go to an urgent care facility. Use the provider directory on our website to find one near you. Or call Customer Service.

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 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.

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

There may be other times you should go to the ER that are not on the list. If you are not sure, call 911, your local emergency number or the 24-Hour Nurseline at 800-830-1525 (TTY: 711).

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.

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.

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 PCP to set up a time to see him or her when you are back home. You can also call your PCP's office or the 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 he or she can plan your follow-up care. You should do this for any emergency at home or away.

Post-stabilization care

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

Part 13: How To Get Your Medicines

SCDHHS has a single Preferred Drug List (sPDL) that includes outpatient preferred products for members in regular Medicaid and members in managed care plans. Managed care plans follow the single Preferred Drug List, covering the same preferred and non-preferred medications. It's important to note that the single Preferred Drug List does not include all medications covered by Medicaid.

For information regarding the SCDHHS single Preferred Drug List program, go to www.scdhhs.gov/providers/pharmacy.

To access the SCDHHS single Preferred Drug List go to SouthCarolina.fhsc.com/providers/pdl.asp.

Healthy Blue uses a list of drugs called a Comprehensive Drug List 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.

TIP
To see the most up-to-date Healthy Blue Comprehensive Drug List, please go to our website at **www.HealthyBlueSC.com**.

Drugs that are on our Comprehensive Drug List may need our approval for coverage. We review pharmacy prior authorization requests within 24 hours from the time we get all required information.

Certain drugs on our Comprehensive Drug List:

- 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 cover one emergency supply fill per prescription per one-hundred and eighty (180) days.

Drugs not on the Healthy Blue Comprehensive Drug List

We must approve payment for drugs that are not on our Comprehensive Drug 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 get 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 Part 16: Getting Help With a Problem to learn more about appeals.

If you would like to know if a drug is on our Comprehensive Drug List, just use the searchable Comprehensive Drug List on our website at www.HealthyBlueSC.com. You can also call Pharmacy Customer Service 24 hours a day, seven days a week at 866-781-5094 (TTY: 866-773-9634).

Limits:

- Substances not controlled are limited to a 31-day supply. However, we cover certain drugs in these categories at a 90-day supply: Asthma; Cholesterol (statins); Oral Diabetes and Hypertension.

Please refer to the searchable Comprehensive Drug List on our website at www.HealthyBlueSC.com.

- We only cover the over-the-counter drugs on our Comprehensive Drug List when your doctor gives you a prescription for them.
- Drugs are only covered for the condition they are approved for.
- To find out if a medication has step therapy or requires prior authorization.
- Syringes and needles you use to inject yourself with medicines like insulin at home are covered under your pharmacy benefit. Syringes or needles you do not use to inject yourself with medicine like insulin at home are covered by your medical benefit.
- Injections your primary care provider (PCP) must give you in the office are covered by your medical benefits, not your pharmacy benefits.
- You must get specialty medications from a participating specialty pharmacy. In urgent cases, we will allow you to get your first fill at a local retail pharmacy.
- Your pharmacy and medical benefit covers these diabetic supplies: test strips, lancets and blood glucose monitors.

Over-the-counter (OTC) drugs with prescription

OTC medicines are those that you would normally buy without a prescription — like aspirin, cold medicine and cough syrup. But Healthy Blue will cover many of those medicines as long as you get your doctor to write a prescription for them. Be sure to visit our website at www.HealthyBlueSC.com to read the Healthy Blue Comprehensive Drug List. It shows all the OTC drugs you can get. Or call Customer Service and ask for a printed list to be mailed to you.

Other things to know

Things to be aware of:

- 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 over-the-counter drugs with a prescription.
- If you leave another plan or regular Medicaid to join Healthy Blue, we will cover drugs needing an approval from us for up to 90 days after you join.

If you have a problem with prescription drug services, please call Pharmacy Customer Service at 866-781-5094 (TTY: 866-773-9634).

Part 14: Keeping Your Family Well

Well visits are a key part of your health care. This section shows some of the preventive care you or your child may need or get during a well visit.

To see a complete and up-to-date list of preventive care recommendations, go to these websites:

Preventive Care Recommendations: www.USPreventiveServicesTaskForce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations*

Shots and Vaccines Recommendations: www.cdc.gov/vaccines/*

Information for Parents With Children: www.cdc.gov/parents/children/*

Be sure to review these guidelines with your doctor and ask questions about what is right for you or your child.

Well-Baby Visits: Birth to 24 Months

Infants need to be seen by a doctor at birth, at the following ages and as the doctor suggests:

- 3 – 5 days old
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months

Babies who leave the hospital less than two days (48 hours) after birth need to be seen by a doctor within two to four days after being born. All infants should receive treatment with an eye ointment to prevent a possible infection passed down by the mother during birth.

During a well-baby visit, your baby's doctor will talk to you about:

- Newborn care, safety and development.
- What and when to feed your baby.
- Parent and family health and well-being.
- Why it's important to minimize your baby's exposure to ultraviolet radiation.

SCREENINGS	WHEN TO GET THEM
Weight, length and head measurement	At each visit
Body mass index (BMI)	At 24 months
Newborn metabolic, such as phenylketonuria (PKU) (when the body is unable to break down protein), sickle cell (an inherited blood disorder) and thyroid screenings	Birth to 2 months old (best checked at 3 to 5 days old) Bilirubin at birth (checks for liver problems)
Critical congenital heart defect (birth defects of the heart)	At birth
Development — brain, body and behavior	At each visit
Hearing	As a newborn and as the doctor suggests

Well-Baby Visits: Birth to 24 Months *continued*

SCREENINGS	WHEN TO GET THEM
Oral and dental health	Referral to a dentist, if needed. Begin yearly dental exams starting at 12 months. Fluoride varnish when teeth start coming in (usually around 6 to 24 months old); fluoride prescription based on your drinking water (from 6 to 24 months old)
Hemoglobin or hematocrit (blood count)	Once between 9 to 12 months
Lead testing	At 12 and 24 months old. Check for risks as the doctor suggests.
Lipid disorder (cholesterol problems)	Check for risks at 24 months.
Autism (a condition that affects social skills and the way one communicates)	At 18 and 24 months
Maternal postpartum depression (after a mother gives birth)	At 1, 2, 4 and 6 months
Tuberculosis	Check for risks as the doctor suggests.

Well-Child Visits: 2 1/2 to 10 Years Old

Depending on your child's age, the doctor may talk with you about:

- How to promote healthy nutrition.
- Exercise, growth, safety and healthy habits.
- Learning or school issues.
- Emotional and mental health.
- Family and home living issues.

SCREENINGS	WHEN TO GET THEM
Height, weight and body mass index (BMI)	Each year
Development — brain, body and behavior	At each visit
Vision	Each year
Hearing	Each year
Oral and dental health	Referral to a dentist if needed Dental exams each year Fluoride varnish on the teeth when the dentist suggests (between 2 1/2 to 5 years old); fluoride prescription based on your drinking water (between 2 1/2 to 10 years old)
Lead testing	Check for risks through age 6.
Hemoglobin or hematocrit (blood count)	Check for risks each year.
Blood pressure	Each year starting at age 3 Check for risks before age 3.
Lipid disorder (cholesterol problems)	Once between ages 9 to 11 Check for risks at all other ages.
Tuberculosis	Check for risks and test as the doctor suggests.

Well-Child Visits: 11 to 20 Years Old

Depending on your child's age, the doctor may talk to you and your child about:

- Growth and development, such as oral health habits, body image, healthy eating, physical activity and sleep.
- Emotional well-being, including mood control and overall mental health.
- Safe sex, especially reducing risks of STIs and STDs and pregnancy.
- Substance use, whether that be drinking alcohol or using tobacco, electronic cigarettes, or prescription or illegal drugs.
- School performance.
- Family and home living issues.
- Safety, such as seat belt use, helmet use and sun protection.
- Firearm safety if you own or are around guns.

You may also get vaccines and these screenings:

SCREENINGS	WHEN TO GET THEM
Height, weight and body mass index (BMI)	Percentile to age 18, then BMI each year.
Development — mind, body and behavior	Each year
Depression	Each year starting at age 12.
Blood pressure	Each year
Vision	Each year
Hearing	Each year
Oral and dental health	Each year; fluoride prescription based on your drinking water (between ages 11 to 16)
Hemoglobin or hematocrit (blood count)	Check for risks each year.
Lipid disorder (cholesterol problems)	Once between ages 9 to 11
STIs, including chlamydia	One routine screening at age 15 or older Every year, if sexually active
Substance use disorder and tobacco addiction	Screen once between ages 15 to 18.

Wellness for Women

During a well-woman visit, the doctor may talk with you about:

- Diet and physical activity.
- Mental health, including depression.
- Oral and dental health.
- Tobacco use, how to quit tobacco and avoiding secondhand smoke.
- Drinking alcohol or using drugs.
- Skin cancer risks.
- Family planning, including:
  - Safe sex.
  - Birth control to help avoid unwanted pregnancy.
  - Spacing out pregnancies to have the best birth outcomes.
- Checking for STIs and STDs, including HIV and hepatitis B, if at risk.
- Folic acid supplements for women of childbearing age.

You may also get vaccines and these screenings:

SCREENINGS	WHEN TO GET THEM
Height, weight and body mass index (BMI)	Each year or as your doctor suggests
Blood pressure	Each year or as your doctor suggests. Recheck high readings at home.
Mammogram (breast X-ray)	Consider screening every two years from ages 50 to 74. Ask your doctor for advice.
Cervical cancer	For ages 21 to 29, do a Pap test every three years. For ages 30 to 65, do a Pap test every three years, a human papillomavirus (HPV) test alone, or a combination Pap test and HPV test every five years. Stop testing at age 65 if the last three Pap tests or last two tests (Pap plus HPV) within the last 10 years were normal. If there was an abnormal Pap test within the past 20 years, ask your doctor.
Colorectal cancer (of the colon and rectum)	From ages 45 to 75, your doctor may suggest one or more of these test options: ◆ Stool (feces) tests: • Fecal immunochemical test (FIT) • FIT-DNA: stool and DNA combo test • Guaiac-based fecal occult blood test (gFOBT) ◆ Visual tests: • Colonoscopy (using a small camera on the end of a flexible tube to look at your entire colon) • CT colonography (using a CT scanner to take images of inside the colon) • Flexible sigmoidoscopy (using a small camera on the end of a flexible tube to look at the last part of your colon, called the sigmoid colon)

Wellness for Women *continued*

SCREENINGS	WHEN TO GET THEM
Chlamydia and gonorrhea	If sexually active and age 24 or younger.
Cholesterol	Statins (cholesterol medicine) may be needed for people ages 40 to 75 who have a high risk of cardiovascular disease, such as heart disease.
Glucose (blood sugar) screening for Type 2 diabetes	As your doctor suggests from ages 35 to 70, especially if overweight or obese. Those with high blood sugar should ask their doctors about preventive interventions to promote a healthy diet and physical activity.
Hepatitis C	Screen between the ages of 18 to 79 years.
Osteoporosis (checks how dense your bones are)	Testing should start no later than age 65. Women in menopause should talk to their doctors about osteoporosis and have the test if at risk.
Lung cancer (with low-dose computed tomography [LDCT])	Beginning at age 50 in those with a 20-pack smoking history and who currently smoke or have quit within the past 15 years

Wellness for Men

During your visit, the doctor may talk with you about:

- Diet and physical activity.
- Mental health, including depression.
- Oral and dental health.
- Skin cancer risks.
- Tobacco use, how to quit tobacco and avoiding secondhand smoke.
- Drinking alcohol and using drugs.

You may also receive vaccines and these screenings:

SCREENINGS	WHEN TO GET THEM
Height, weight and body mass index (BMI)	Each year or as your doctor suggests
Abdominal aortic aneurysm (enlarged blood vessels in the abdomen)	Once between ages 65 to 75 if you have ever smoked
Blood pressure	Each year or as your doctor suggests. Recheck high readings at home.
Cholesterol	Statins (cholesterol medicine) may be needed for people ages 40 to 75 who have a higher risk of cardiovascular disease, such as heart disease.
Colorectal cancer (of the colon and rectum)	From ages 45 to 75, your doctor may suggest one or more of these test options: ◆ Stool (feces) tests: • Fecal immunochemical test (FIT) • FIT-DNA: stool and DNA combo test • Guaiac-based fecal occult blood test (gFOBT) ◆ Visual tests: • Colonoscopy (using a small camera on the end of a flexible tube to look at your entire colon) • CT colonography (using a CT scanner to take images of inside the colon) • Flexible sigmoidoscopy (using a small camera on the end of a flexible tube to look at the last part of your colon, called the sigmoid colon)
Glucose (blood sugar) screening for Type 2 diabetes	As your doctor suggests from ages 35 to 70, especially if overweight or obese. Individuals with high blood sugar should ask their doctors about preventive interventions to promote a healthy diet and physical activity.
Hepatitis C	Screen between the ages of 18 to 79 years.
Prostate cancer	From ages 55 to 69, talk with your doctor about the risks and benefits of prostate cancer tests.
Lung cancer (with low-dose computed tomography [LDCT])	Beginning at age 50 in those with a 20-pack smoking history and who currently smoke or have quit within the past 15 years.

Vaccines

People of all ages need vaccines, or "shots," as we often call them.

VACCINES	BIRTH	1 – 2 MONTHS	2 MONTHS	4 MONTHS	6 MONTHS	6 – 18 MONTHS	12 – 15 MONTHS	15 – 18 MONTHS	19 – 23 MONTHS
COVID-19	Given per CDC and ACIP recommendations								
Hepatitis B	√	√				√			
Rotavirus (RV)			Two-dose or three-dose series						
Diphtheria, tetanus and pertussis (DTaP)			√	√	√			√	
Tetanus, diphtheria and pertussis (Td/Tdap)									
Haemophilus influenzae Type b (Hib)			Three to four doses between 2 to 15 months with first dose at 2 months, last dose at 12 to 15 months						
Pneumococcal conjugate (PCV20)			√	√	√		√		
Inactivated polio virus (IPV)			√	√		√			
Influenza (flu)					Suggested each year from 6 months to 65+ years. Two doses at least four weeks apart are recommended for children between 6 months to 8 years old having the vaccine for the first time.				
Measles, mumps and rubella (MMR)							√		
Varicella (chickenpox)							√		
Hepatitis A							Two-dose series between 12 to 23 months, taken six to 18 months apart		
Human papillomavirus (HPV)									
Meningococcal									
Monoclonal RSV injection	One injection before or during RSV season for newborns and infants up to 8 months old								
RSV									
Zoster (HZ/su)									

Vaccines *continued*

VACCINES	4 – 6 YEARS	11 – 12 YEARS	13 – 18 YEARS	19 – 64 YEARS	65+ YEARS
COVID-19	Given per CDC and ACIP recommendations				
Hepatitis B	See age recommendation on previous page.				
Rotavirus (RV)	See age recommendation on previous page.				
Diphtheria, tetanus and pertussis (DTaP)	√				
Tetanus, diphtheria and pertussis (Td/Tdap)		Tdap		Every 10 years	
Haemophilus influenzae Type b (Hib)	See age recommendation on previous page.				
Inactivated polio virus (IPV)	√				
Pneumococcal conjugate (PCV20)				Ages 19 – 64 with underlying health risk factors	√
Influenza (flu)	Suggested each year from 6 months to 65+ years. Two doses at least four weeks apart are recommended for children between 6 months to 8 years old having the vaccine for the first time.				
Measles, mumps and rubella (MMR)	√				
Varicella (chickenpox)	√				
Hepatitis A	See age recommendation on previous page.				
Human papillomavirus (HPV)		Two-dose series			
Meningococcal		√	Booster at age 16; MenB FHb at ages 16 to 23		
Monoclonal RSV injection	See age recommendation on previous page.				
RSV				Maternal RSV: Given per CDC and ACIP recommendations RSV: Ages 60 and older	
Zoster (HZ/su)				19 and older if immunocompromised Two-dose for ages 50 and older	

Part 15: Managing Your Health

People have unique 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.

My Health Planner

My Health Planner is a free app. It connects you with a team of clinicians and other health workers. Use your smartphone or tablet to:

- Stay in control of your health.
- Understand what you need to do to feel your best.
- Keep track of what you need to do between doctor visits.
- Stay in touch with your care management team.

To get started:

1. Search for **My Health Planner** on the App Store or Google Play.
2. Download the **My Health Planner app** and select **Create New Account**.
3. Use access code **WELCOMEHB**.

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.
- Help with finding a provider.
- Send health records to your doctors when they need them.

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

If you think you need case management services or would like to learn more about the CM program, call Customer Service at 866-781-5094 (TTY: 866-773-9634). 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.

Chronic Condition Care/Population Health Program

Our Chronic Condition Care/Population Health (CCC/PH) Program can help you get more out of life when you have certain conditions. Licensed clinicians and health educators will help you learn how to better manage your illness. You can choose to join our CCC/PH Program at no cost to you.

We offer our CCC/PH Program for these conditions:

Chronic kidney disease (CKD)

This program helps members with stages 1 – 3 kidney disease. Members can learn how to manage their illness. You'll also see how to reduce your risk of having other complications that CKD may cause.

COPD

This educational program is for members with chronic obstructive pulmonary disease (COPD). COPD is a chronic disease of the lungs. It really consists of two diseases: chronic bronchitis and emphysema.

The number one cause of COPD is cigarette smoking. You can also get it from other things. COPD can be a serious illness. You can help manage it with proper medicine and simple lifestyle changes.

Chronic and Persistent Mental Health Condition

Have you been diagnosed with a chronic and persistent mental health condition like major depression, bipolar disorder, schizophrenia or OCD. You are not alone. Our program has trained behavioral health care managers to help you better understand your condition and best ways to cope through the ups and downs.

Diabetes

Let us help you learn how to manage your diabetes better. We teach you how to reduce your risk of complications and improve your quality of life. This includes things like healthy eating, taking your medications and exercise.

ER diversion

This program is to reduce emergency room utilization for nonemergent issues through education on alternative sites of care, provide appropriate resources and post-visit follow-up to serve individual needs.

Heart disease

Our heart disease program helps you learn how to better manage your heart disease. Our goal is to help you understand more about your condition. We can also show you steps you can take toward good health.

Heart failure

We can teach you how to better manage your congestive heart failure (HF). Our goal is to help you learn to manage your symptoms so you can keep doing the things you enjoy.

High blood pressure

This program is for members who want to learn more about managing high blood pressure and making lifestyle changes to manage your risk factors.

High cholesterol

This program for members who want to learn how to lower their cholesterol levels. We'll also show you how to make lifestyle changes to manage important cardiovascular risk factors.

Maternity

Pregnancy is a time of changes in your body and emotions. It can also be overwhelming. You may have questions. Our program gives you information and support throughout your pregnancy and postpartum period. Be sure to read Part 11: Benefits for Pregnant Members and New Moms.

Metabolic health

This program helps those who struggle with obesity or prediabetes. We will work with you to develop a plan to reach your health goals. This includes helpful information on eating healthy, exercising and losing weight.

Migraine

This program helps members who suffer from severe and recurrent headaches. We'll show you the importance of having a doctor to guide your headache management. We'll also teach you how to identify and avoid things that trigger your headaches.

NICU case management

This program supports the parents of infants with certain medical needs or conditions. This includes complications due to premature birth, congenital birth defects, seizures, cystic fibrosis and genetic disorders.

Recovery support

When you or a loved one begins to live healthier, we want you to know you are not alone. This program is for members and their families. Recovery from substance abuse is an ongoing process. The program will support you throughout every stage of your recovery.

Tobacco cessation

It's hard to stop smoking. Nicotine is a highly addictive drug. Many people find they need help quitting tobacco. Our Tobacco Cessation program can help you stop the habit. We provide information, support and resources to help you become tobacco-free.

Weight management

Changing your eating and exercise habits can be tough. Americans invest billions of dollars each year in weight-loss diets with no results. So, how do you guarantee results? By making slow and gradual changes that can last a lifetime. Our program will help you make lasting changes that lead to long-term results.

Joining a CCC program

If you qualify for a CCC program, we will send you a letter and ask you to call us. You may also refer yourself or your child by calling Customer Service toll free at 866-781-5094 (TTY: 866-773-9634) Monday through Friday from 8 a.m. to 6 p.m.

You can also send us a secure email through My Health Toolkit.

Once you qualify, we will set you up with a CCC care manager to get started. Your care manager will ask you some questions about your or your child's health.

Your CCC care 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 ways to make it better.
- 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 doctor visits.
  - Referring you to specialists in our health plan, if needed.
  - Getting any medical equipment you may need.
- Offer educational materials and other tools.

Useful phone numbers

In an emergency, call 911.

For CCC, call Customer Service toll free at 866-781-5094 (TTY: 866-773-9634) Monday through Friday from 8 a.m. to 6 p.m. local time. Leave a private message for your care manager 24 hours a day.

After hours, call the 24-Hour Nurseline 24 hours a day, seven days a week at 800-830-1525 (TTY: 711).

You can opt out of the CCC program at any time. Please call Customer Service toll free at 866-781-5094 (TTY 866-773-9634) from 8 a.m. to 6 p.m. local time Monday through Friday and ask us to take you out of the CCC program.

Care management rights and responsibilities

When you join a CM or CCC 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 skills or education.
  - Any deals we have with other companies.
- Opt out of CCC services.
- Know which CCC care manager is handling your CCC services and how to ask for a change.
- Get support from us to make health care choices with your doctors.
- Ask about all 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 doctors.
- 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.
- Get polite, respectful treatment from our staff.
- Be given information that is clear and easy to understand.
- File complaints to Healthy Blue by calling Customer Service and:
  - Get 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 CCC program.

You also have a responsibility to:

- Follow the care plan that you and your CCC care manager agree on.
- Give us information we need to conduct our services.
- Tell us and your health care providers if you choose to leave the program.

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

You can log in to your secure My Health Toolkit account or register at www.HealthyBlueSC.com to ask us to join a CCC program. You will need your member ID number to register. It's on your member ID card. Using your secure account, you can send a secure message and ask to join the program.

How to get other services

You may want to participate in programs Healthy Blue does not offer. Call Customer Service if you think these programs may help you.

Part 16: Getting Help With a Problem

This section describes appeals and grievances:

- A **grievance** is a complaint about something other than an adverse benefit determination.
- An **appeal** is a request to review an adverse benefit determination.

An 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 and resolve grievances and appeals in a timely manner.
- Deny a request to get services outside your network if you live in a rural area with only one managed care organization (MCO).

We want you to be happy with the service you receive. If you have a problem, we want to hear from you. 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.

Grievances

A grievance is when you tell us you are not happy about anything other than an adverse benefit determination. For example, you can 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.

Who may file a grievance

You or a person you choose to act for you, such as a friend, family member, provider or lawyer, can file a grievance at any time. You can do this verbally or in writing. If you choose to ask someone to file a grievance for you, you must give us your written OK. You can mail us your written permission.

Customer Service staff can help you file your grievance. If you need help, 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.

To file a grievance, you or the person you choose to act for you can do one of these:

- Call Customer Service.
- Fill out and submit the Member Grievance Form. You can find a copy on our website at www.HealthyBlueSC.com
- Write a letter and send it to us.
- Send us a secure message through My Health Toolkit.

Be sure to tell us:

- Who is involved in the grievance.
- What happened.
- When and where it happened.
- Why you are unhappy.

Attach any papers you think will help us look into your issue. Mail these to:

Healthy Blue — Grievances
Mail Code AX-405
PO Box 100317
Columbia, SC 29202-3317

If you cannot mail these, you or the person acting for you should call Customer Service.

If you or the person you choose files your grievance by phone, the Customer Service advocate will try to resolve it during this first call or no later than the end of the next business day.

Within **seven** calendar days of getting your grievance in writing, we will send you a letter letting you know we got it. Grievances received by phone are verbally acknowledged during the call. Within 90 calendar days, we will send you a letter that tells you what we've done to resolve your grievance.

Grievance extensions

Healthy Blue may take an extra 14 calendar days if the member requests an extension or we need more information and time to decide, and if the extra time is in the member's best interest. If this happens, we will call you as soon as we can to let you know. We'll also send you a letter within two calendar days with the reason for the extension and telling you about your right to file a grievance if you disagree with the decision.

Grievances about discrimination

For grievances about discrimination, you or the person acting for you 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 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 the person acting for you can find the complaint form at www.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.

Confidentiality and Discrimination

We handle all grievances and appeals in a confidential manner. Healthy Blue does not discriminate against a member for filing a grievance or for requesting a state fair hearing. Healthy Blue also notifies members of the opportunity to receive information about our grievance and appeal process and the ability to request a translated version in a language other than English.

Grievances and complaints of discrimination

Healthy Blue does not discriminate against any member. Members who contact Healthy Blue with an allegation of discrimination are immediately informed of the right to file a grievance. This also happens when one of our representatives working with a member identifies a potential act of discrimination. The member is advised to submit an oral or written account of the incident and is assisted in doing so if he or she requests assistance.

Appealing a grievance decision

If you file a complaint (also called a grievance) and are not happy with the decision, you have the right to appeal it. A grievance appeal is when you ask us to go back over the decision made about your grievance. When you appeal a grievance decision, we will look at your case again and provide you with a final answer. Once we complete the grievance appeal and tell you of the outcome, the process is done. You can't make further grievance appeals for the same complaint after that. If your appeal is about getting a service covered or reversing a denied service, that is called a coverage appeal. That follows a different process. If you don't know which type of appeal applies to your case, please contact us. We will help guide you through the process. For more information or to file an appeal, please call Customer Service.

Within seven calendar days of getting your grievance appeal in writing, we will send you a letter letting you know we got it. We acknowledge requests we get by phone verbally during the call. Within 90 calendar days, we will send you a letter that tells you what we've done to resolve your appeal.

Appeals

You may ask for an appeal when we make an adverse benefit determination.

If we make an adverse benefit determination, we will send you and your doctor a letter telling you why. This letter will also tell you how to file an appeal.

You can ask for an appeal of coverage for a medical service that:

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

Who can file an appeal

You, your doctor or someone you choose to act for you can ask for an appeal. This person can be anyone you choose, including a lawyer. This person is called an authorized representative.

If you want a representative to ask for an appeal for you, you must submit a Member Appeal Representative Form or send us a letter. You can find the form on our website at www.HealthyBlueSC.com. If you send a letter, be sure to:

- Write the date on the letter.
- Write the full name of your representative.
- Tell us you want this person to file an appeal on your behalf.
- Sign the letter.

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

- A minor under the age of 16. Minors ages 16 or older will need to submit a Member Appeal Representative Form to have someone act on their behalf.
- Incompetent, or not able to act for mental reasons.*
- Incapacitated, or not able to act for physical reasons.*

*Documentation such as a medical power of attorney or incapacitated dependent form required.

How and when to file an appeal

You or your representative may ask for an appeal within 60 days of our adverse benefit determination.

You can ask for an appeal one of these ways:

- Call Customer Service.
- Fill out and submit the Member Appeal Form. You can find it on our website at www.HealthyBlueSC.com.
- Write a letter and send it to us at:

  Healthy Blue — Appeals
  PO Box 100215
  Columbia, SC 29202-3215

Once you start an appeal, be sure to get any information you think we should have to review your appeal. If you think you need more time to do this, you can ask us to add up to 14 calendar days to your appeal time.

Customer Service staff can help you file your appeal or handle your request for more time to gather and send us your information. If you need an interpreter, we will provide one at no cost to you.

When to expect a response

Within **five calendar days** of getting your appeal, we will send you a letter. It will tell you we received your appeal request. This letter will also tell you or the person acting for you of your right to give us more information in writing or in person within **seven calendar days** of the letter. It will also tell how to request a free copy of your case file. This file contains:

- Your health records.
- Other documents and records used in the original denial.
- New or more information that we will use in the appeal.

Within 30 calendar days of your appeal request, we will resolve your appeal. We will send you a letter that tells you what we decided, when we made that decision and the specific reason for it.

Expedited (rush) appeals

You can ask for a rush appeal if you think waiting 30 calendar days for our decision may harm your health. To ask for a rush appeal, you may call us, fax us or mail us a letter. Be sure to tell us why you think waiting 30 calendar days will harm your health.

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

- Call you within 72 hours to tell you what we decided.
- Mail the decision to you.

If the appeals nurse thinks waiting 30 calendar days will not harm your health, we will call or fax you to tell you that. We will also send you a letter within two calendar days. The letter will let you know we will complete your appeal as fast as we can within the standard 30 calendar-day time frame.

You or your representative may file a grievance if you disagree with the decision to change the rush appeal to a regular appeal.

Standard and expedited appeal extensions

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 or the person acting for you and send a letter within two calendar days of making our decision to extend the time frame. The letter will explain:

- The reason for the delay.
- How you may file a grievance if you disagree with our decision to add more time to our review.

We will resolve the appeal as quickly as your health condition requires and no later than the date the extension ends.

State fair hearing

If you are not happy with the appeal decision, you or the person acting for you has the right to ask for a state fair hearing with SCDHHS.

You may ask for a state fair hearing **within 120 calendar days** from the date of the appeal notification letter. To ask for a state fair hearing, you or the person you choose to act for you can:

- Go to www.scdhhs.gov/appeals*.
- Mail a written request to:

  Division of Appeals and Hearings *
  1801 Main St.
  PO Box 8206
  Columbia, SC 29202
- Fax your request to 803-255-8206.
- Email your request to appeals@scdhhs.gov.

For help or questions, call 803-898-2600 or 800-763-9087.

Keeping your benefits during your appeal or state fair hearing process

You may keep your previously approved benefits for the appealed service while Healthy Blue reviews your appeal and while you wait for your state fair hearing. All of these things must happen:

- You request that your benefits continue within 10 calendar days from the date on your adverse benefit determination notice.
- The appeal has to do with coverage for a service that has been delayed, reduced or 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 or hearing request.
- Ten days have passed after we sent you a 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.

Part 17: Fraud, Waste and Abuse

What is fraud?

Fraud means deceiving or misrepresenting information on purpose, knowing it could cause you or someone else to get an unapproved benefit. Fraud can be:

- Using someone else's Social Security number to get government help.
- A doctor billing for services he or she did not give (on purpose, not due to a mistake).

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:

- A doctor prescribing more medicine than medically necessary.
- A doctor providing more health care services than medically necessary.

What is abuse?

Abuse is something that creates unnecessary costs for government programs such as Medicaid. Abuse may also result in improper benefits to a member or improper payment to doctors. Examples of abuse include:

- Asking for and getting medications or medical equipment for someone else.
- Excessive use of the ER for nonemergency or routine care.

How to report fraud, waste and abuse

If you believe a doctor, dentist, counselor, etc. or someone with health benefits (Medicaid, Medicare, 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. There are four ways to report fraud, waste or abuse to us:

- Call the BlueCross BlueShield of South Carolina Fraud Hotline toll free at 800-763-0703.
- Use the form on this website: www.SouthCarolinaBlues.com/web/public/brand/sc/assistance/report-fraud.
- Fax the form to our anti-fraud unit at 803-870-8356.
- Write to us:

  BlueCross BlueShield of South Carolina Anti-Fraud Unit
  Mail Code AC-200
  PO Box 24011
  Columbia, SC 29224-4011

You may also call the South Carolina Medicaid Fraud Hotline at 888-364-3224 or email fraudres@scdhhs.gov.

When you report a provider, give these details:

- Name, address and phone number of the provider
- Name and address of the 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 someone who receives benefits, 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 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 18: If We Can No Longer Serve You

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

Healthy Blue cannot cover you 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 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 16: Getting Help With a Problem. It 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 South Carolina Healthy Connections Choices, 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, please call Customer Service.

Part 19: Other Things You Need To Know

If you have questions that have not been answered yet, read this part for the answers.

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 getting your medical records from your doctor, call us.

Advance directives

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 or 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. 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. Both of these are types of advance directives.

A living will lets your doctor know what types of treatments you do and do not want when you are terminally ill or in a persistent vegetative state and cannot make your own choices. In South Carolina, the Declaration of Desire for a Natural Death form serves as a living will.

A health care power of attorney lets you name someone to act on your behalf. This person can tell the doctor what types of medical care you want. You can also have a separate power of attorney specifically for mental health treatment and care. In South Carolina, you can sign a form, the Declaration for Mental Health Treatment, that will replace a durable power of attorney for mental health.

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 family members chosen by state law, a person chosen by a court or the court itself.

If you have questions about signing a health care power of attorney or living will, you should talk to your doctor, lawyer, minister, priest, rabbi or other clergy who give advice.

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 get 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 get these forms from the 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 aging.sc.gov/programs-initiatives/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 South Carolina Department of Public Health by calling 803-898-3300 or the South Carolina Lieutenant Governor's Office on Aging by calling:*

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

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, the group will look at it. They will let your doctor know if the treatment is medically necessary and if we approve it.

Physician incentive plans

You have the right to know if your primary care provider (PCP) is part of a program in which we provide financial rewards based on the services and quality of care your PCP provides. To learn more about this, call Customer Service.

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 get details about our QI program by calling Customer Service. We can send you more details on the program and a report on how we are doing to meet our improvement goals.

Out-of-area care

Healthy Blue's service area is in every county 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
- The 24-Hour Nurseline
- Customer Service

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 ER for routine care.

Privacy

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 get information from anyone giving you care. We use this information 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 Customer Service.

Part 20: Member Rights

You or your doctor can get a copy of these rights and responsibilities:

- Call Healthy Blue Customer Service to ask us to mail, email or fax a copy. Our telephone number is 866-781-5094 (TTY 866-773-9634).
- Go to our website at www.HealthyBlueSC.com.

Member rights

You have the right:

- To be treated with respect and regard for your dignity and privacy.
- To take part in decisions about your health care.
- To refuse treatment.
- To be free from threats or acts to get even with, coerce, punish or inconvenience you, as noted in federal rules.
- To ask for and get a copy of your medical records and ask that we change or correct them.
- To be told if your PCP leaves our network. We must let you know no later than 30 days before that happens or 15 days after we are notified that your PCP has left the network.
- To access health care services that compare in amount, length and scope to those under Medicaid fee-for-service (FFS). You can also reasonably expect these services to achieve the purpose for which they are given.
- To get appropriate services and not have them denied or reduced solely due to the diagnosis, type of illness or medical condition.
- To get all information in a manner and format that is easy to understand. This includes, among other things, enrollment notices, informational materials, and treatment options and alternatives in a manner that matches your condition and ability to understand.
- To get help from both SCDHHS and us in understanding our rules and benefits.
- To get free translation services for all non-English languages.
- To get free oral interpretation services.
- To get information, as a potential member, about the basic features of managed care so that you can make an informed choice. This includes who may or may not enroll in the program. It also includes what we must do to coordinate care in a timely manner.
- To get information on Healthy Blue services. You can visit our website at www.HealthyBlueSC.com or call our Customer Service at 866-781-5094. Learn about:
  - Benefits we cover.
  - How to get benefits, including any prior authorizations you may need.
  - Service area.
  - Names, locations, telephone numbers and non-English languages spoken by network providers. This includes, at the least, PCPs, specialists and hospitals.
  - Limits on your freedom of choice among network providers.
  - Providers not taking on new patients.
  - Benefits we do not offer but that you can still get. This includes how to get those benefits and how to get transportation.

- To get full details of your right to disenroll at least each year.
- To get notice of any major changes in your benefits. We must let you know at least 30 days before the change takes effect.
- To learn how to file a grievance or appeal.
- To learn how to ask for a state fair hearing.
- To get information on emergency and after-hours coverage. This includes, but is not limited to:
  - What we consider emergency medical conditions, emergency services and post-stabilization services.
  - The fact that emergency services do not need prior authorization.
  - How to get emergency services.
  - Where to get emergency and post-stabilization services that we cover.
  - Your right to use any hospital or other place for emergency care.
  - Post-stabilization care services rules.
- To get our policy on referrals for specialty care and other benefits your PCP does not provide.
- To have us protect your privacy.
- To use these rights without harming the way we, our providers, or SCDHHS treats you.
- To frankly discuss appropriate or medically necessary treatment options, regardless of cost or benefit coverage.
- To voice complaints or appeals about us or the care you get.
- To suggest changes to this policy.

Member responsibilities

You have these responsibilities:

- Tell us and the state Medicaid program when your life changes. This includes if you move, change your phone number or get other insurance. It also means if you are pregnant or the number of people in your household changes. Please tell us if your ID card is lost or stolen.
- Show your ID cards each time you get care.
- Keep and be on time for doctor visits. When you must cancel or be late, call the doctor's office and let them know.
- Treat your PCP and staff with respect.
- Work with your doctors to understand your health and set your treatment plan goals.
- Ask questions and make sure you understand what your doctor tells you.
- Follow the treatment plan you and your doctor have worked out. Tell your doctor if you can't follow the plan.
- Give your doctors and us as much information as you can. We use it to help you get well and stay well.
- Know how to seek emergency care.
- Use the emergency room only for true emergencies, not routine care.
- Read all of our materials carefully when you enroll.
- Follow the rules of our plan.
- Fill out and send your renewal form each year. You will get this form from South Carolina Healthy Connections Medicaid.
- Call us when you need us.

Part 21: Words We Use

Here are some of the meanings of the words we use 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 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 MCO.

Advance directive is 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 OK ahead of time from us.

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.There are now $0 copays for both medical and pharmacy benefits as of July 1, 2024. The South Carolina Department of Health and Human Services (SCDHHS) has removed all copays for these services. This applies to both Healthy Connections Medicaid and Healthy Blue members.

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 or you changed your health plan.

DMH means South Carolina Department of Mental Health.

Durable medical equipment is equipment that provides therapeutic benefits or lets beneficiaries do certain tasks that they are unable to undertake otherwise due to certain medical conditions and/or illness.

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.

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a provider that is qualified to furnish these services under this title.
- Needed to evaluate or stabilize an emergency medical condition.

Excluded services are Medicaid services not included in the Healthy Blue core benefits and that are reimbursed fee-for-service by the State.

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

Health insurance may include any individual accident and health policy or group policy that provides payment for health care costs. A provider that accepts a Medicaid beneficiary as a patient is required to request payment from all available third-party resources prior to billing Medicaid. All third-party claims filed must be assigned to the provider.

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

Home and community-based services help people with long-term care needs to remain at home as authorized in an approved 1915(c) Waiver or 1915(i) State Plan.

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 used 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.

Nonparticipating provider refers to a physician licensed to practice who has not contracted with or is not employed by Healthy Blue to provide health care services.

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

Plan (a.k.a. Health Plan) is interchangeable with the terms contractor, managed care plan or HMO/MCO.

Premium is a monthly fee that may be paid to Medicare or Medicaid.

Primary care provider (PCP) is the provider you have for most of your health care. This person helps you get 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 individual or entity furnishing Medicaid services under a provider agreement with Healthy Blue or the Medicaid agency. These may include any individual, group, physician (such as but not limited to primary care providers and specialists) or entity (such as but not limited to hospitals, ancillary providers, outpatient centers [free-standing or owned], clinics and laboratories) furnishing Medicaid services under an agreement with the Medicaid agency.

For the Medicaid managed care program, this means any individual, group, physician (including but not limited to primary care providers and specialists) or entity (such as but not limited to hospitals, ancillary providers, clinics, outpatient centers [free-standing or owned] and laboratories) that is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers 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 South Carolina Department of Public Health (DPH)
- Licensed professional counselor — a person who is trained to treat mental 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, including when she is pregnant or giving birth
- Occupational therapist — a health professional 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 health professional 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 mental health issues and prescribes drugs
- Psychologist — a person who treats mental health issues but does not prescribe drugs

- Registered nurse — a nurse with more training than a licensed vocational nurse and who has a license to perform certain duties with your doctor
- Respiratory therapist — a health professional who helps you with your breathing
- Speech pathologist — a health professional who helps you with your speech
- Surgeon — a doctor who can operate on you

Provider network refers to the providers with which a managed care organization (MCO) contracts or makes arrangements to furnish covered health care services to Medicaid members under an MCO coordinated care or network plan.

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 or injury.

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

Second opinion is your right to see one more doctor to have him or her give an 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. A second opinion from an out-of-network provider requires prior authorization. Call Customer Service if you would like to find another doctor for a second opinion.

Single Preferred Drug List (sPDL) refers to a single, state-directed PDL for all participating MCOs and the fee-for-service (FFS) Medicaid program that the SCDHHS implemented effective July 1, 2024. A PDL is a list of outpatient drugs covered under the pharmacy benefit that health care payers use to encourage providers to prescribe certain drugs over others. A PDL is not a comprehensive list of all medications covered by Medicaid. The state's PDL is in the pharmacy section of the SCDHHS website. Though the single PDL will be established by SCDHHS, prior authorization processes and criteria for nonpreferred drugs are not changing through the transition to a single PDL. For Healthy Connections Medicaid members who are enrolled in an MCO, providers will still use the prior authorization process and criteria established by the MCO.

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

South Carolina Healthy Connections Medicaid is the state Medicaid agency that brings you health care services. It is part of SCDHHS.

Specialist refers to a health care professional who treats only certain parts of the body, certain health conditions or certain age groups.

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) or value-added benefits (VABs) are items and services provided to members that are not included in the core benefits and are not funded by Medicaid dollars. Health care-related VAIS or VABS are items or services that are intended to maintain or improve the health status of members.

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. By law, we must follow the terms of the notice currently in effect.

This notice went into effect Sept. 23, 2013, and will remain in effect until we change or replace it. 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 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 get 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 www.HealthyBlueSC.com.

HOW WE USE OR SHARE YOUR HEALTH RECORDS

We may use or share your health records:

- For treatment. For example, we may share information to help your doctor provide your treatment and give you proper care.
- For payment. For example, we may use your records to help us pay the bills your provider sends us.
- For health care operations. For example, we may use records to help us run our health plan and ensure you receive quality care. We may not use or share genetic information for underwriting purposes.
- To help manage your health. For example, 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, like those 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:

- With state and federal agencies that manage us. For example, we may need to share records with the South Carolina Department of Health and Human Services.
- With a public health agency. For example, records may help avoid a serious public health or safety threat.
- With a court of law.
- With law enforcement. For example, we may have to share health records to help stop child abuse.
- With a coroner, medical examiner or funeral director to help find a cause of death.
- With a medical facility for organ donor or transplant purposes.
- With government officials. For example, we may have to share health records 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 personal health information (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, which includes race/ethnicity, preferred language, gender identity and sexual orientation:

- 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 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 IDENTITY

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

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 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 get a paper copy of this notice, please call Customer Service at 866-781-5094 (TTY: 866-773-9634). We are available Monday through Friday from 8 a.m. to 6 p.m.

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

CONTACT INFORMATION

Healthy Blue
Privacy Officer
Mail Code AX-E13
PO Box 100317
Columbia, SC 29202-3317

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.

Non-Discrimination Statement and Foreign Language Access

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

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

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

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

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

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

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

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

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

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

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

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

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)

Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)

HEALTHY BLUE ◆ PO BOX 100317 ◆ COLUMBIA, SC ◆ 29202-3317

Customer Service: 866-781-5094 (TTY: 866-773-9634) Monday – Friday from 8 a.m. – 6 p.m.
24-Hour Nurseline: 800-830-1525 (TTY: 711)

@HealthyBlueSC @HealthyBlueSC @HealthyBlueSC @HealthyBlueSC

www.HealthyBlueSC.com

Healthy Blue℠
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Healthy Connections

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

220554-4-2025