

MyChoice Health Plans

Member Handbook



Your Voice. Your Health Insurance. Your Choice. | www.cchpsc.org





Welcome to Consumers' Choice Health Plan

Thank you for your interest in choosing Consumers' Choice Health Plan as your partner for health care coverage. Our goal every day is to offer a new way for care delivery to you and your family.

Like our name says, we take pride in knowing we are the only choice that gives you, the consumer, a voice in the process. We are mission-based and the needs of you and your family remain at the center of everything we do.

A solid, trusted choice, *Consumers' Choice* is licensed by the South Carolina Department of Insurance and meets all state regulations and guidelines for operation. We are also approved by the United States Department of Health and Human Services as a Consumer Operated and Oriented Plan (CO-OP). There are 24 CO-OPs in 23 states around the country.


A first for South Carolina, we are proud to be the only health insurance consumer operated and oriented plan (CO-OP) in the state. The purpose of CO-OP development is to offer individuals and businesses more health insurance options that are high quality, yet provide a better value.

CO-OPs also give its Members a voice in how their health care coverage is delivered. Our business model is unique.

- **We are nonprofit.** Our savings go back into the health plan to keep it high quality and to give a better value.
- **We are Member-governed.** You have the opportunity to serve on the board of directors. You finally have a voice.
- **We focus on prevention.** You work with your doctor to create the best treatment plan.

Creating a community of caring, we understand that the health of our Members is based on many things. Some of these things are not medical in nature. This is why we have partnered with community organizations that provide the extra support our Members may need to help them reach their health goals and maintain the best health possible.

With *Consumers' Choice*, you belong to a team of professionals who share the same goal, good health, healthy families and a healthier community.



Jenylo Buzgen
President/CEO

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Your Rights and Responsibilities as a Member

Member Rights

- You have the right to privacy, and to be treated with respect and dignity.
- You have the right to receive a Member handbook, and if requested, in another language or format.
- You have the right to an interpreter to aid you in better understanding your benefits.
- You have the right to make recommendations regarding our Member rights and responsibilities policy.
- You have the right to participate in and make decisions about your treatment and care, including the right to refuse treatment and the right to request a second opinion.
- You have the right to ask about different treatment options for your condition and the right to be able to discuss those treatment options with your doctors regardless of cost or benefit coverage.
- You have the right to ask for copies of your medical records from your doctors.
- You have the right to information about our doctors that includes the doctor's education, board certification, and re-certification.
- You have the right to ask questions of your health plan or provider, and to file a complaint or appeal about our services, our participating providers or about our organization, without fear, discrimination, retaliation, reprisal or repercussion.
- You have the right to receive a timely response or resolution to your question, complaint or appeal.
- You have the right to receive a copy of our Member rights and responsibilities annually.

Member Responsibilities

- It is your responsibility to supply information to your doctors and the organization in order to stay healthy or get healthy, and to ask questions so that you can understand your health status.
- It is your responsibility to participate in developing a mutually agreed upon treatment goal if you become ill. This includes making and keeping appointments.
- It is your responsibility to follow the treatment plan and instructions agreed upon by you and your doctors.
- It is your responsibility to read and understand the materials provided to you by Consumers' Choice Health Plan concerning your benefits and to contact the plan if you have questions.
- It is your responsibility to present your ID card, identifying you as our Member before receiving care.
- It is your responsibility to notify Consumers' Choice Health Plan or your doctor of any enrollment changes such as family size, address changes, or whether you have other health insurance.
- It is your responsibility to fulfill any financial obligations as it relates to payments as stated in your policy.

Consumers' Choice Health Plan provides covered services to all eligible Members regardless of: age, race, religion, color or disability.

We Are Here For You

Our Members are our most valued asset; therefore, we promise to listen, to treat them with courtesy and respect; to keep them informed and to partner with them and our healthcare community in improving their health.

Get Involved In Your Health Care



Visit www.cchpsc.org

The *Consumers' Choice* website is full of helpful information. You will find many health topics at your fingertips 24 hours a day. You can find a doctor and register online through our Member login area. You can also learn about our special health programs.



Register Online to Create Your Account

Visit www.cchpsc.org and create an account in the Member area. The Member login is a self-service area is just for your health care coverage information. You can do the following things and more by logging in as a Member:

- Check on a claim
- View your benefit plan, including yearly deductibles
- Order a new or replacement ID card
- View your enrollment and eligibility information
- View and print your Explanation of Benefits (EOB)
- View the Provider Directory



Call Us

If you do not have internet access, call Customer Service at 800-580-8736. Our team of caring professionals is ready to help.

We Are Here For You

My Health Choice

My Health Choice is the name of our health management program. *My Health Choice* includes education and prevention. You can also earn rewards and incentives! *My Health Choice* is a great way to improve your health. Here are some examples of the programs available through *My Health Choice*.

- Nutrition
- Exercise
- Blood Pressure
- Cholesterol
- Smoking Cessation
- Weight Management
- Stress Management
- Back Care

Visit www.cchpsc.org and look for *My Health Choice* to get started. You will see a Health Risk Assessment (HRA) to fill out. The HRA is a great way to help you figure out where to begin in *My Health Choice*.

Understanding Your Benefits

If you need help understanding your benefits, call 800-580-8736 or log on to www.cchpsc.org. We can also give you information in another language. We have Customer Service Representatives that speak both English and Spanish. If you speak another language we can connect you with an interpreter. Members with hearing loss can use their TTY machine or dial 711. You will need to provide the 800 number listed on the back of your insurance card. You can also call 800-545-8279 directly.

This handbook is just a summary. Your plan's policy is called the Evidence of Coverage (EOC). The EOC has complete information. Also, see your Summary of Benefits and Coverage (SBC).

Your ID Card

Your ID card will be sent in your Welcome Packet. Carry this card with you at all times. Your benefits are paid using the information on your card. Even if you do not have a doctor's appointment, you need it if you have an emergency and have to go to an emergency room. You also need your ID card to pick up prescriptions. If you lose your ID card, go online to the Member Login section of our website or call Customer Service to order a new one.



Covered Benefits

Consumers' Choice Health Plan encourages our Members to select a Primary Care Physician or PCP. A PCP is your main health care provider in non-emergency situations. Your PCP's role is to:

- provide preventive care and teach healthy lifestyle choices.
- identify and treat common medical conditions.
- assess the urgency of your medical problems and direct you to the best place for that care.
- refer you to medical specialists when necessary.

More information about Primary Care can be found in this handbook and can also be found in "Choosing a Primary Care Provider" on our website, or by calling Customer Service at 800-580-8736. If you do not select a PCP, we will choose one for you.



Understanding Your Benefits

Your health care coverage includes different levels of care. Here is a closer look at each level.

- Preventive Care
- Primary Care
- Specialty Care
- Urgent Care
- Emergency Care
- Hospital Care
- Mental Health and Substance Abuse Care
- Out-of-Network Care, if included in your plan
- After-Hours Care
- Out-of-Service Area Care



Preventive Care

Preventive care are services that help you stay healthy. They help reduce your chances of getting diseases. Most preventive care by our network providers is covered at no cost to you. Here are some examples of preventive care that are covered by your plan. Please see your EOC for a complete list.

- Well-child care such as vaccines and other screenings
- Well-woman care such as mammograms and tests for female cancers
- Well-adult care such as high blood pressure and Type 2 diabetes screenings

Primary Care

Consumers' Choice Health Plan promotes the "medical home" model for care. Your medical home is the main place for all your care. We ask that you choose a PCP as your medical home.

There are different practice types with PCPs. Some are:

- Family Medicine
- Internal Medicine
- Pediatrics

Why should you choose a PCP? Studies have shown that patients with this type of care have improved their health. The medical home approach to care has also been shown to lower costs. That is why we ask you to choose a PCP when you enroll. If you do not choose a PCP, we will choose one for you.

Choosing a PCP is easy, just go to www.cchpsc.org and use our online Provider Directory to find a PCP near you. If you do not have internet access, just call us and Customer Service will guide you through the

process so that you can choose the PCP that is best for you. If you want to change your PCP, log on to your member profile at www.cchpsc.org, or call Customer Service with your selection and we will make the change for you.

You can set a time to visit your doctor by calling his or her office directly to make an appointment. Your PCP's staff will help you throughout your office visit.

When you visit your PCP, you may be treated by other health care providers. They may be a nurse practitioner (NP), a physician's assistant (PA) or a certified nurse midwife (CNM). All of these providers are covered under your primary care benefits.

Specialty Care

You do not need a referral to receive specialty care. It's always a good idea to discuss treatment options with your PCP first. He or she may recommend that you see a specialist. Specialists are doctors that focus on treating certain conditions. An example of a specialist is an allergist. An allergist treats people who have allergic reactions. Your PCP can help you decide if this type of treatment is right for you.

Urgent Care

Urgent care is when you need immediate medical attention and your PCP's office is closed. If you cannot reach your PCP, you may visit an urgent care center in the *Consumers' Choice* network. Let your PCP know about any urgent care visits as soon as possible. He or she may need to update your records or give follow-up care. If it is not an emergency, contact your PCP who should have on-call services to help you. If not, go to the nearest urgent care center in the *Consumers' Choice* network. Search the Provider Directory by visiting www.cchpsc.org.

Different Types of Medical Care

Emergency Care

You do not need a referral or authorization to receive emergency care. If you have a medical emergency, dial 911 or go to the nearest hospital emergency room. The emergency room does not have to be in our network. Report all emergency room visits to your PCP's office as soon as possible. This allows your PCP to update your medical records. Your PCP may also need to follow-up with your treatment.

Some types of emergencies are:

- Trouble breathing
- Severe or unusual bleeding
- Chest pains
- Severe choking
- Possible poisoning
- Seizures or convulsions
- Broken bones
- Fainting or other loss of consciousness
- Severe burns
- Vaginal bleeding during pregnancy
- Severe pain not controlled by pain medicine

Please refer to your EOC for a definition of Emergency Care.

Hospital Care

Sometimes an illness or injury requires services or treatment only found in a hospital. Your benefits cover hospital care if it is medically necessary.* The care may be inpatient or outpatient. A brief overview is below. Please see your EOC for more information.

Inpatient - One or more overnight stays in a hospital. An inpatient stay does require an authorization.

Outpatient - Services you receive in a hospital that do not require an overnight stay. Certain outpatient services require an authorization.

Mental Health and Substance Abuse Care

Mental health care is the type of service you may receive when dealing with an illness like clinical depression. Substance abuse care is the type of service that help those coping with alcohol or drug addiction. Contact a Consumers' Choice Health Plan behavioral health practitioner if you need this type of care.

You do not need a referral to see this type of health care provider. You can find a behavioral health care practitioner in the Provider Directory at www.cchpsc.org. You can also call Customer Service at 800-580-8736.

Out-of-Network Care * *

Out-of-network (OON) care are services from a provider who is not in the Consumers' Choice Health Plan network. Please check your SBC to find out if your benefit plan covers OON services. If your benefit plan does not cover OON services, you may be responsible for the cost of those medical services.

After-Hours Care * *

When you need care after regular business hours, on weekends or holidays, this is called after-hours care. If it is an emergency, dial 911 or go to the nearest hospital emergency room. If it is not an emergency, contact your PCP who should have on-call services to help you. If you can't reach your PCP, go to the nearest urgent care center. Search the Provider Directory by visiting www.cchpsc.org.

Out-of-Service Area Care * *

Consumers' Choice Health Plan is for South Carolina residents. In 2014, our coverage will be offered in the entire state of South Carolina. If you are traveling outside the service area and need medical services, there are still network providers available. Search the Provider Directory at www.cchpsc.org to find a provider near you.

You have benefits for emergency services, even if the provider is not in network. Depending upon your plan, you also may have benefits for out-of-network care. If you cannot find a provider in the online directory, call Customer Service at 800-580-8736. They will assist you in finding care nearby.

Non-Covered Benefits

Some services are not covered. They are called "Limitations and Exclusions." Most medically necessary services are covered by your health insurance benefits. Please see your EOC or SBC for more information about services that are not covered.

** See page 13 to learn more about medical necessity.*

***Out-of-network, after-hours and out-of-service area care guidelines do NOT apply if you have an emergency. If you have an emergency, call 911 or go to the nearest hospital emergency room.*

Selecting a Primary Care Physician

Your primary care physician (PCP) is more than just the person you call when you feel sick or get hurt. Your PCP is focused on keeping you healthy. Like a good coach, this doctor will encourage you to make healthy lifestyle choices.

Why do we require that you choose a PCP? Studies have shown that patients with this type of care have improved their health. The medical home approach to care has also been shown to lower costs. That is why we ask you to choose a PCP when you enroll. If you do not choose a PCP, we will choose one for you.

Who Provides Primary Care?

You can choose a PCP from one of the three practice types listed below:

- Family Medicine
- Internal Medicine
- Pediatrics

Consumers' Choice Health Plan has a wide range of PCPs under these three specialties from which you can make your selection. It's easy. Visit our website at www.cchpsc.org, log in to your Member account online and begin your search. You can also call Customer Service at 800-580-8736 and one of our representatives will be able to assist.

Board certification is shown on our website for each specialty, so look for these credentials as you begin your search. Additional resources to research the doctor's education, certification and performance history can be found on websites such as www.abms.org and www.ama-assn.org.

Helpful Tips to Remember When Selecting a Primary Care Physician

- **YOU** have the right to choose a PCP from your health plan's provider network.
- **ASK** for referrals from friends and family rather than picking a doctor at random from your health plan's provider directory or out of the phone book.
- **VERIFY** if the PCP you selected is accepting new patients.
- **CHECK** to make sure the PCP is in your plan's network.

Other things you may want to consider:

- Is your doctor's age a factor?
- Would you prefer a male or female doctor?
- Is the location convenient for you and your family?
- Do they have after hours care?
- What about their cancellation and payment policies?

Your Next Steps

Schedule an appointment with your top choice to go over your medical history, discuss your health concerns and determine if that doctor is a good fit for your needs.

After the appointment, ask yourself the following questions:

- Did you feel comfortable talking with this person?
- Did you feel rushed?
- Does the physician's personal style match your own?
- Were you encouraged to call with questions?
- Was the office staff courteous and helpful?

Start building your health care team by choosing your PCP TODAY!



You Have a Voice

There are three ways to contact us. You can:

- Call us at the number at the bottom of the page
 - Send us an email from our website
 - Write us a letter about the problem and send it to:
Consumers' Choice Health Plan
c/o HealthSCOPE Benefits
P.O. Box 91606
Lubbock, TX 79490-1606
-

We care about the service you get from our health care providers and us. We would like to talk to you if you have questions. If you do not speak English, we will have someone interpret for you. You can also allow someone else to talk to us on your behalf. Some of the questions we can help you with are:

- Your benefits or how your claims were paid
- How much you may have to pay the doctor or facility
- Finding a provider within or outside of our network
- Our care management and wellness programs

Problems or Complaints

We would like to talk to you if you have a problem or a concern. Call us. We are here to help. Most of the time we are able to resolve your problem right away or in a few days. Here are some of the issues we can help you with:

- When we do not pay for a service (in part or in full)
- When we say “no” to a service you asked for
- When we reduce or limit the approval of a service that you asked for
- When we fail to respond to your requests in a timely manner
- When you have a problem with the quality of the service you received

We can help you to file a complaint or an appeal over the phone, or you can write us. You will not be treated differently for filing a complaint or an appeal. You can also file a complaint with the South Carolina



Department of Insurance. Our Customer Service staff is here to help.

Appeals

An appeal is a request from you to the health plan to review or change a decision that we have made. You have 180 days from the time you receive our decision to file an appeal. If your need is urgent due to your health status, you can ask for your request be expedited or reviewed much faster. If we say no to your faster appeal request we will:

- Call you right away to let you know
- Change your faster appeal request to a standard appeal
- Follow the standard appeal process

You will need to tell us as much as you can about the problem. Also, send us any paperwork that you may have to help us look into the problem. We would like to know:

- What happened and where
- Who else may be involved
- Why you were not satisfied

When we receive your appeal by phone or mail, we will send you a letter within five days acknowledging that we have received your request. We may need to talk to the doctors who gave you care before we make our decision or may need more information from you. You also have the right to present your case in person. The letter you receive will explain the process.

We will let you know our decision within 30 days about your standard appeal request. We must let you know our decision within 72 hours for faster appeal requests. You will receive a letter from us telling you about our final decision. If our final decision was to deny your appeal, we will send you a letter. The letter

Using Customer Service

will tell you about your rights to have someone else review your appeal. This is called an external appeal. We will pay to have this review completed. It will be at no cost to you. The decision by the external reviewer is final and binding to both of us.

Claims

Claims are paid based on the benefit plan that you selected. Your network provider will file your claim to the plan when you receive care. We will pay your provider directly and you will be responsible for your share. There are some instances where you will have to file the claim to the plan. An example of this is when you use a provider that is not in our network. If your plan has out-of-network benefits, you will have to pay the provider first then file the claim to us to be reimbursed. Here are the instructions for filing a claim:

- You have 180 days from the date of service to file your claim to us.
- Visit our website and print the Member claim form or call us and we will mail it to you.
- You will need information such as your name, Member ID, date of birth and address; a bill from your provider that shows the *Consumers' Choice* charge for each service you received, the total *Consumers' Choice* charges for all services received; the name, address and tax identification number of the provider, the date of service, diagnosis and procedure codes for the service you received.
- You will also need to include a copy of your receipt.
- Fill out the form and mail it to the address listed on the form.
- Your claim will be processed and the money sent to you unless you tell us otherwise.

Explanation of Benefits

The plan sends a notice to you when your claims are processed. This notice is called an Explanation of Benefits, or EOB. The EOB shows the action taken by the plan and provides the details of how the claim processed. It will show how much the plan paid your



TO FILE A CLAIM:

Visit www.cchpsc.org

- print the member claim form or call us and we will mail it to you

Fill out the form

- mail it to the address on the form

Information You Will Need

- member ID
- date of birth and address
- a bill from your provider that shows the date of service, diagnosis and procedure codes and amount charged for each service you received
- the name, address and tax identification number of the provider
- a copy of your receipt

provider, the services you received, the date of the service and the amount of money you may owe the provider.

The EOB will also show if we did not process or pay your claim and tell you how to file an appeal. In some cases, we may need more information before we can process your claim. We will tell you what information is needed and provide an explanation of why we need it. If your claim was denied payment by the plan, we will tell you why. We will state the specific reason or reasons for not paying your claim and refer to your benefit plan rules on which the denial was based. Call us if you do not understand how to read your EOB. We are here to help.

Caring For You

Our promise to you is that:

- Our clinical team is committed to making sure you receive the highest quality of care.
 - The decisions made, regarding your care, are based solely on what is best for you within your covered benefits.
-

Medical Management

The process of working with your health care providers to decide if and how medical services are covered is called Medical Management. There are different parts of the MM process. Some of these are:

- Case Management
- Disease Management
- Utilization Review
- Preauthorization

Case Management

Some Members have special health care needs. Our caring clinical team has nurses and social workers called Case Managers. They are ready to help you learn more about your condition and get the care you need. Even if more than one doctor is treating you, your Case Manager will work to coordinate your care.

Disease Management

Our care management programs help you with on-going medical conditions. Some of the conditions we offer management programs for are:

- Coronary Artery Disease
- Diabetes
- Depression
- Attention Deficit with Hyperactivity Disorder (ADHD)

If you have one of these conditions and would like to be included in one of these programs, call Customer Service at 800-580-8736 or log on to your Member profile at www.cchpsc.org to get enrolled.

Utilization Review

If you need care from a hospital or other health care facility, your doctor and our clinical team will work together to make sure this admission is the best treatment for you. They will also work to make sure you

are getting the care you need and that all procedures are covered. This process is called utilization review (UR).

Preauthorization

It is important that you get the care you need in the right setting. Preauthorization is the process we use to decide if services are medically necessary.* Some of your covered benefits or services must be preauthorized. Some of these are:

- In-patient hospital stays
- Skilled nursing center care
- Home health services
- Advanced testing such as MRIs (magnetic resonance imaging)

Evaluating New Technology

At Consumers' Choice Health Plan, we are always looking at new technological advances in medical procedures and services. Our panel of physicians regularly checks to make sure you get the safest, most up-to-date and highest quality of care. Our process for evaluating technology for benefit coverage includes:

- Comparing benchmarks
- Checking FDA and Medicare approvals
- Reviewing medical journals
- Studying the purpose of each technology
- Studying the impact of the technology
- Developing guidelines on how and when to use new technology

We Promise

Medical Management (MM) decision-making is based only on appropriateness of care and service and existence of coverage. We promise that the decisions made, regarding your care, are based solely on what is best for you within your covered benefits.

* See page 13 to learn more about medical necessity.

Caring For You

- The organization does not specifically reward doctors or other individuals for issuing denials of coverage. We promise that our providers and employees are not rewarded to deny you coverage.
- Financial incentives for MM decision makers do not encourage decisions that result in under-utilization. We promise that our providers and employees are not rewarded to decrease your coverage.

Here To Help

If you have questions or concerns, our clinical team is just a phone call away. We are available at 1-800- 580-8736 during normal business hours. In addition to our normal business hours, our clinical team is available by phone after hours, as needed. Language assistance and TDD/TTY phone services are also available.

When our clinical team contacts you regarding your care management, they will identify themselves by name and title.

What Is Medical Necessity?

Medically necessary services are generally accepted by the medical community provided in light of conditions present at the time of treatment. A physician or other health care professional, as appropriate, reviews these services.

These services are:

- Essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a Member
- Provided at an appropriate facility and at the appropriate level of care for the treatment of a Member's medical condition
- Provided in accordance with generally accepted standards of medical practice (See previously stated adopted clinical practice guidelines listed under PCP availability)
- Consistent with medical benefits defined by the organization, including hospitalization and emergency services listed in the Evidence of Coverage (EOC)

- Consistent with care or services that could be considered either covered or non-covered, depending on the circumstances, including decisions on requests for care that may be considered experimental
- Consistent with denials for behavioral healthcare based on non-covered services
- Consistent with pharmacy-related denials including step-therapy or prior authorization cases
- Consistent with decisions about dental procedures that are covered under the Member's medical benefits. If dental and medical benefits are not differentiated in the organization's benefits plan, the organization must identify the services or care as if there is differentiation. This means identifying only care or services associated with medically necessary medical or surgical procedures that occur within or adjacent to the oral cavity or sinuses.

Benefit Decisions for You

A benefit determination is a denial of a requested service that is specifically excluded from a Member's benefit plan.

Benefit determinations include the following:

- Services that are limited by number, duration or frequency in the Member's benefit plan
- Denials for extension of treatments beyond the specific limitations and restrictions imposed in the Member's benefit plan
- Decisions about care that do not depend upon a Member's medical need or a doctor's order

There must be no other effective and more conservative or substantially less costly treatment, service and setting available.

Consumers' Choice Health Plan does not cover experimental or investigational procedures or drugs for which insufficient evidence exists to provide reasonable assurance of safety and effectiveness. A medical necessity review of such requests will be performed unless the requested service or procedure is specifically listed as excluded in the Member's benefit plan.

Caring For You

Information necessary for notification authorization may include but is not limited to:

- Member's name, ID number, DOB, demographics
- Doctor's name and telephone number
- Hospital or Facility name, if the request is for an inpatient admission or outpatient services
- Reason for admission – primary and secondary diagnoses, surgical procedures, surgery date
- Relevant clinical information – past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed
- Admission date or proposed surgery date, if the request is for an inpatient admission
- Proposed 48- hour observation bed
- Anticipated length of stay, if the request is for an inpatient admission
- Discharge plans, if the notice/request is for an inpatient admission
- For obstetrical (OB) admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate

If more information is required, the caller will be notified of the specific information needed to complete the notification/authorization process. If your doctor does not have access to the Internet, he or she may call 800-580-8736 and ask for a paper copy of our Care Management guidelines to be mailed.

Failure to provide notification/obtain authorization may result in payment denials. Please refer to the appeals section of your Evidence of Coverage (EOC).

Your Prescription Drug Benefit

Prescription drugs treat illnesses or injuries that are managed by a doctor or health care provider. Only a licensed doctor or health care provider can write a prescription. You take the prescription to a drugstore or pharmacy. A pharmacist gives you the drug you need.



Consumers' Choice partnered with Catamaran to be your Pharmacy Benefit Manager (PBM). A PBM processes and pays the prescription drug benefit part of your health insurance. Your health plan helps with costs for prescription drugs. These drugs must be needed for your medical treatment.

Your prescription drug benefits are made up of a list of products that are covered by your plan. This list is called the Formulary. It is a guide for your doctor or other health care provider. It helps him or her choose the best drug at the lowest cost for you.

The Formulary can be found at www.cchpsc.org or by calling Customer Service at 800-580-8736.

Keeping Costs Low

One way to keep your cost low is by asking your doctor if a generic drug is right for you. Generic drugs cost less than brand-name drugs.

Generic and brand-name drugs work the same. The U.S. Food and Drug Administration (FDA) makes sure that all generic drugs are safe and work as well as brand-name drugs. You can find out if your brand-name drug has a generic by looking at the Formulary.



Filling Your Prescriptions

You can only get prescription drugs through a doctor or other licensed health care provider. The provider writes a prescription for the medicine you need. You take or mail the prescription to a drugstore to get your medicine.

Show your *Consumers' Choice* ID card to the pharmacist at any of the drugstores in our network. They use your card information to make sure you pay the right amount. Keep your cost the lowest by staying

with a drugstore in our network. Your ID card benefits will not work at drugstores or pharmacies outside of our network.

You may also use the mail order pharmacy. It usually costs less than going to a local retail pharmacy. You also don't have to refill as often. Use the Catamaran mail order pharmacy for a 90-day drug supply.

Different types of drugs have different costs, called tiers. Generic drugs cost less than brand-name drugs. Here are the cost tiers, from lowest to highest:

- Preventive medications are covered at no cost to you
- Generic drugs have the lowest cost and the lowest Member copay expense
- Preferred brand name have a higher cost
- Non-preferred brand name have the highest cost
- Specialty pharmaceuticals

If you need a drug that is not covered by your plan, you or your PCP may request an exception by submitting supporting information to us. A panel consisting of physicians and registered pharmacist will review this information to determine medical necessity and whether an exception to the formulary will be allowed.

More information to help you understand your pharmacy benefits is below.

Preventive Medication Coverage

Preventive medicines help keep you from getting sick. They are free to you. This means that they are covered at no cost to you. You can find a list of preventive medicines in the Formulary.

Prescription Drug Benefits

Prior Authorization

This means that your doctor's office needs to call Catamaran to make sure your health plan will help cover the cost of certain drugs.

Some reasons for prior approval are:

- Medicines that are often not prescribed the right way
- Medicines that could be used the wrong way
- Medicines that might not be the best choice for your health condition
- Medicines that require another drug be tried first
- Medicines that are approved only for a certain number of doses
- Very expensive medicines

Quantity Limits

Some medications have limits on the number of doses that will be covered under your health plan. Your doctor may want you to have more than what we normally help cover. If so, he or she should call the PBM to make sure it is needed and will be covered.

Step Therapy

Step Therapy makes sure that you try one drug before trying something else. The first drug (Step 1) works for most people who have a condition like yours. This is typically a lower cost medicine. If that does not work, the health plan helps pay for a second drug (Step 2). Your doctor should call the PBM if he or she wants you to skip a step.

Specialty Pharmacy Medications

Specialty medicines are different from drugs you can buy at the drugstore. They are used to treat on-going or rare conditions. Your pharmacy benefits help you get the special medicine you need at a lower cost.

You may only get up to a 30-day supply of specialty drugs at one time. Your cost for the specialty drug is based on your health plan and the Formulary. Only BriovaRx, the Catamaran specialty pharmacy, can send you specialty medicine.

Your Pharmacy Network

Your health plan has chosen the Catamaran Pharmacy Network, which has more than 65,000 drugstores. These pharmacies make up your pharmacy network. Many national chains and independent pharmacies are included. Visit www.chatn.org for the complete network pharmacy list. You can also call Customer Service at 800-580-8736. **If you use pharmacies that are not in our network, no benefits will be paid.**

Have questions about your prescription benefits?
Contact our Customer Service Department at 800-580-8736.

Understanding How Much You Pay

Consumers' Choice Health Plan pays for your covered benefits, but you also pay for parts of your coverage.



Deductible

The deductible is a fixed maximum dollar amount that you pay before benefits are paid. Your health plan may have a yearly deductible. This means you will pay for all services until that amount is reached.

Example: If your deductible is \$1,000, you pay for the first \$1,000 of costs for the year and then your benefits start.

Coinsurance

You and Consumers' Choice Health Plan will share treatment costs. Your portion of the costs is a fixed percentage of the allowed amount. This is called coinsurance.

Example: Consumers' Choice Health Plan pays 80% for services and you pay the remaining 20%.

Copayments

A copayment, sometimes called a copay, is a fixed dollar amount you pay for a covered service. You pay this amount at the time of treatment. The amount will be different based on the type of care you receive.

Example: A PCP office visit may have a \$15 copayment.

Yearly Maximum Out of Pocket (MOOP)

The MOOP is the most you will pay for covered medical treatment during your plan year. It is a fixed dollar amount. Once you reach your MOOP, *Consumers' Choice* will begin paying 100 percent of your covered services. Once you meet the MOOP for the plan (policy) year, no additional MOOP will be required for the plan year.

All copayments, coinsurance amounts and deductibles are applied to the yearly MOOP. Money paid for insurance premiums is not included in your MOOP total. Please refer to your plan information for more details.

Using the Provider Network

We have many quality providers in our network. They were put through a careful background check. We reviewed the information below for each one.

- Education
- Training
- License
- Board Certification
- Malpractice
- Prescriptions
- Work History

The *Consumers' Choice* Provider Network is an open access network, meaning you may choose to see any doctor in our network without a referral. We ask that you choose a PCP from our network when you enroll. If you do not choose a PCP, we will choose one for you. Your PCP will coordinate your care.

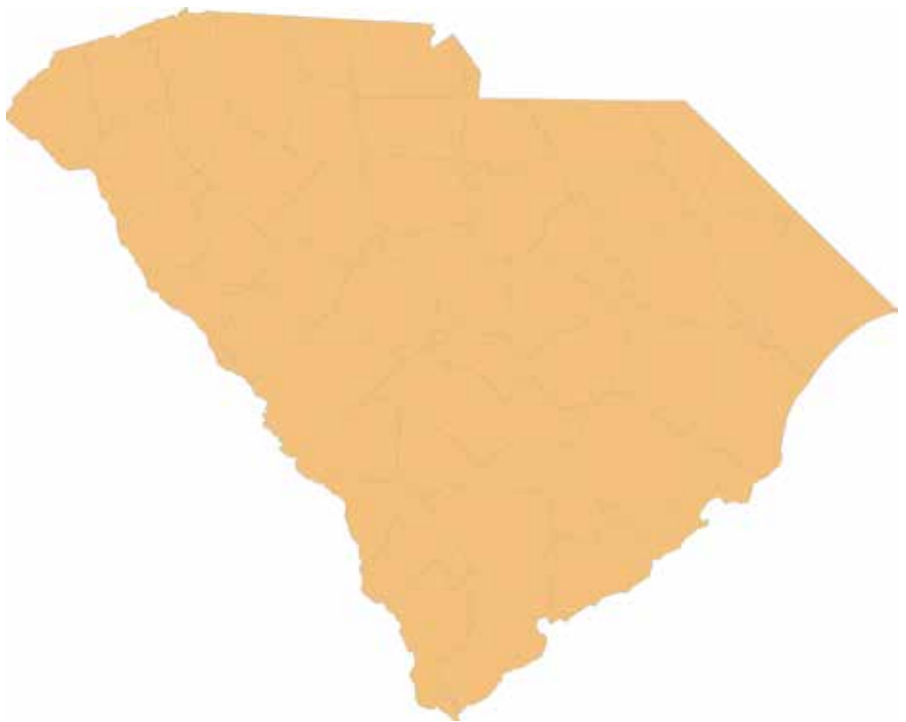
**Network guidelines do NOT apply if you have an emergency. If you have an emergency, call 911 or go to the nearest hospital emergency room.*

Our network also has specialists, hospitals and other providers who can provide treatment when needed. Visit www.cchpsc.org to view the Provider Directory and search for a PCP. With our online search tool you can search for a Provider by:

- Name
- Gender
- Specialty
- Hospital affiliations
- Medical group affiliations
- Board certification
- Accepting new patients
- Languages spoken by the doctor or his staff
- Office locations

Additional information related to doctors such as where they attended medical school and where they did their residencies is also available.

If you do not have access to the internet, you may call Customer Service at 800-580-8736.



Important Privacy Information

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY. THEN, KEEP IT ON FILE FOR REFERENCE.

LEGAL OBLIGATIONS - CONSUMERS' CHOICE HEALTH PLAN, and some subsidiaries and affiliates (CCHP) are required to maintain the privacy of all medical information as required by applicable laws and regulations (hereafter referred to as "legal obligations"); provide this notice of privacy practices to all Members, inform Members of the company's legal obligations; and advise Members of additional rights concerning their medical information. They must follow the privacy practices contained in this notice from its effective date of April 14, 2003, until this notice is changed or replaced.

CCHP reserves the right to change its privacy practices and the terms of this notice at any time, as permitted by the legal obligations. Any changes made in these privacy practices will be effective for all medical information that is maintained, including medical information created or received before the changes are made. All Members will be notified of any changes by receiving a new notice of the company's privacy practices.

You may request a copy of this notice of privacy practices at any time by contacting CCHP at the address on the back of this notice

ORGANIZATIONS COVERED BY THIS NOTICE -

This notice applies to the privacy practices of CCHP and some subsidiaries and affiliates, if any. Medical information about Members may be shared among these organizations as needed for treatment, payment or healthcare operations. As the company procures or creates new business lines, they may be required to follow the terms defined in this notice of privacy practices.

USES AND DISCLOSURES OF MEDICAL INFORMATION - Your medical information may be used and disclosed for treatment, payment, and health care operations. For example:

TREATMENT: Your medical information may be disclosed to a doctor or hospital that asks for it to provide treatment.

PAYMENT: Your medical information may be used or disclosed to pay claims for services, which are covered under your health insurance policy.

HEALTH CARE OPERATIONS: Your medical information may be used and disclosed to determine premiums, conduct quality assessment and improvement activities, to engage in care coordination or case management, accreditation, conducting and arranging legal services, and for other similar administrative purposes, as allowed under the Patient Protection and Affordable Care Act, as amended, and the Health Care and Education Reconciliation Act of 2010.

AUTHORIZATIONS: You may provide written authorization to use your medical information or to disclose it to anyone for any purpose. You may revoke your authorization in writing at any time. That revocation will not affect any use or disclosure permitted by your authorization while it was in effect. The company cannot use or disclose your medical information for any reason except those described in this notice, without your written authorization.

PERSONAL REPRESENTATIVE: Your medical information may be disclosed to a family Member, friend or other person as necessary to help with your health care or with payment for your health care. You must agree that the company may do so, as described in the Individual Rights section of this notice.

PLAN SPONSORS: Your medical information, and the medical information of others enrolled in your group with CONSUMERS' CHOICE HEALTH PLAN, may be disclosed to your plan sponsor in order to perform plan administration functions. Please see your plan documents for a full description of the uses and disclosures the plan sponsor may make of your medical information in such circumstances.

UNDERWRITING: Your medical information may be received for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a health insurance or benefits contract, as allowed under the Patient Protection and Affordable Care Act, as amended, and the Health Care and Education Reconciliation Act of 2010. If the company does not issue that contract, your medical information will not be used or further disclosed for any other purpose, except as required by law.

MARKETING: Your medical information may be used to provide information about health-related benefits, services or treatment alternatives that maybe of interest to you. Your medical information may be disclosed to a business associate assisting us in providing that information to you. We will not market products or services other than health-related products or services to you unless you affirmatively opt-in to receive information about non-health products or services we may be offering.

RESEARCH: The company's legal obligations permit your medical information to be used or disclosed for research purposes. If you die, your medical information may be disclosed to a coroner, medical examiner, funeral director or organ procurement organization.

AS REQUIRED BY LAW: Your medical information may be used or disclosed as required by state or federal law.

COURT OR ADMINISTRATIVE ORDER: Medical information may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

VICTIM OF ABUSE: If you are reasonably believed to be a victim of abuse, neglect, domestic violence or other crimes, medical information may be released to the extent necessary to avert a serious threat to your health or safety or to the health or safety of others. Medical information may be disclosed, when necessary, to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

MILITARY AUTHORITIES: Medical information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. Medical information may be disclosed to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities.

USE AND DISLOCURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES OTHER THAN TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

In the event CCHP wishes to use or disclose Member PHI or if the Member requests CCHP to use or disclose Member PHI in a manner that is not allowed under the Privacy Act, an authorization will be obtained from the Member who will specifically authorize such use and disclosure.

INTERNAL PROTECTIONS OF YOUR PHI

CCHP protects oral, written and electronic PHI throughout our organization. We do not sell PHI to anyone. We have many internal policies and procedures designed to control and protect the internal security of your PHI. These policies and procedures address, for example, use of PHI by our employees. In addition, we train all employees about these policies and procedures. Our policies and procedures are evaluated and updated for compliance with applicable laws.

INDIVIDUAL RIGHTS

You have the right to look at or get copies of your medical information, with limited exceptions. **You must make a written request, using a form available from the Privacy Officer, to obtain access to your medical information. If you request copies of your medical information, you may be charged 25¢ per page, \$10 per hour for staff time required to copy that information, and postage if you want the copies mailed to you. If you request an alternative format, the charge will be based upon the cost of providing your medical information in the requested format. If you prefer, the company will prepare a summary or explanation of your medical information for a fee. For a more detailed explanation of the fee structure, please contact the Privacy Officer. The company requires advance payment before copying your medical information.**

You have the right to receive an accounting of any disclosures of your medical information made by the company or a business associate for any reason, other than treatment, payment, or health care operations purposes after April 14, 2003. This accounting will include the date the disclosure was made, the name of the person or entity the disclosure was made to, a description of the medical information disclosed, the reason for the disclosure, and certain other information. If you request an accounting more than once in a 12-month period, there may be a reasonable cost- based charge for responding to those additional requests. Please contact the Privacy Officer for a more detailed explanation of the fees charged for such accountings.

You have the right to request restrictions on the company's use or disclosure of your medical information. The company is not required to agree to such requests. **The company will only restrict the use or disclosure of your medical information as**

set forth in a written agreement that is signed by the Privacy Officer on behalf of the company.

If you reasonably believe that sending confidential medical information to you in the normal manner will endanger you, you have the right to make a written request that the company communicate that information to you by a different method or to a different address.

If there is an immediate threat, you may make that request by calling a CCHP Customer Service Representative at the number listed on your ID Card or the Privacy Officer at the number listed below. Follow up with a written request is required as soon as possible. The company must accommodate your request if it is reasonable, specifies how and where to communicate with you, and continues to permit collection of premium and payment of claims under your CCHP benefit plan.

You have the right to make a written request that the company amends your medical information. Your request must explain why the information should be amended. The company may deny your request if the medical information you seek to amend was not created by the company or for other reasons permitted by its legal obligations. If your request is denied, the company will provide a written explanation of the denial. If you disagree, you may submit a written statement that will be included with your medical information. If the company accepts your request, reasonable efforts will be made to inform the people that you designate about that amendment. Any future disclosures of that information will be amended.

If you receive this notice on the company's Web site or by electronic mail (email), you may request a written copy of this notice by contacting the Privacy Officer.

QUESTIONS AND COMPLAINTS

If you want more information concerning the company's privacy practices or if you have questions or concerns, please contact the Privacy Officer.

If you are concerned that: (1) the company has violated your privacy rights; (2) you disagree with a decision made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information; (3) to request that the company communicate with you by alternative means or at alternative locations; please contact the Privacy Officer. You may also submit a written complaint to the U.S. Department of Health and Human Services. The company will furnish the address where you can file

a complaint with the U.S. Department of Health and Human Services upon request.

The company supports your right to protect the privacy of your medical information. There will be no retaliation in any way if you choose to file a complaint with CCHP or subsidiaries and affiliates, or with the U.S. Department of Health and Human Services.

CONSUMERS' CHOICE HEALTH PLAN

Attn: Privacy Officer

4995 Lacross Road, Suite 1300

North Charleston, SC 29406

Phone: 843.747.6300

Fax: 843.735.5458

E-mail: PrivacyOfficer@cchpsc.org

IMPORTANT INFORMATION

Customer Service

Phone: 800-580-8736

Email: customerservice@cchpsc.org

Mailing Address:

Consumers' Choice Health Plan

c/o HealthSCOPE Benefits

P.O. Box 91606

Lubbock, TX 79490-1606

Consumers' Choice Health Insurance Company
4995 Lacross Road, Suite 1300
North Charleston, SC 29419
888-537-0055
www.cchpsc.org