Qualified Health Plans
Essential Benefits

South Carolina

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Since 1974

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Essential Benefits

The Affordable Care Act requires all Qualified Health Plans (BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina [referred to as "the company.]) to cover essential health benefits (EHB), which include items and services in these 10 categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services including dental and vision care

The Affordable Care Act also directs that EHB be equal in scope to benefits offered by a "typical employer plan." To meet this requirement in every state, states must select a benchmark plan. The final rule provides that all plans offer benefits substantially equal to the benefits offered by the benchmark plan.

There are also standards included in the final rule to protect consumers from discrimination and ensure that benchmark plans offer a full array of EHB benefits and services. For example, the final rule:

- Prohibits discriminatory benefit designs.
- Includes special standards and options for coverage of benefits not typically covered by individual and small group policies today, including habilitative services.
- Includes standards for prescription drug coverage to ensure that individuals have access to needed prescription medications.

Ambulatory Patient Services

Ambulatory care is a personal health consultation, treatment or intervention using medical technology or procedures that are delivered on an outpatient basis. Examples include:

- Primary care and specialist care office visit to treat an injury or illness
- Other practitioner office visit
- Outpatient surgical
- Diagnostic medical procedures (biopsy, endoscopy, etc.)
- Home health care services

Emergency Services

The company must provide coverage without the need for prior authorization, regardless of network status, without imposing limitations that are more restrictive than

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an in-network provider. Benefits must be provided at the in-network cost sharing level; however, the member can be balanced billed for services rendered at an out-of-network provider.

- Out-of-Network Emergency Room – The company will provide benefits for emergency medical care in an emergency room from an out-of-network provider. The allowed amount will be based on the Medicare allowance at a South Carolina out-of-network provider. For out-of-network providers outside of South Carolina, we will use the local Blue Plan's out-of-network allowance or the Medicare allowance.
- Out-of-Area Emergency Services – The company will provide benefits for emergency medical care from an out-of-network provider if the member meets all of these conditions:
    - They were traveling for reasons other than seeking medical care when the emergency medical condition occurred.
    - They were treated for an accident or new emergency medical condition.

An emergency condition is an illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. This includes illness or injury to an unborn child.

Services that must be covered are:

- Exams, procedures and supplies rendered in an emergency or urgent care facility
- Emergency transportation/ambulance

Hospitalization

Coverage includes, but is not limited to:

- Hospital semiprivate room and board
- Special care units such as burn, intensive care and coronary care
- Surgical services
- Anesthesia administration
- Medical supplies, oxygen, blood, blood plasma and blood expanders
- Laboratory and X-ray services
- Physician services — daily medical visits and consultations

Maternity and Newborn Care

Allowable charges are covered for all expectant mothers. Allowable charges are also covered for the newborn if:

- The newborn is added to a group policy within 30 days of birth or
- The parents or guardians apply for an individual policy for the infant within 60 days of birth

Coverage includes, but is not limited to:

- Prenatal and postpartum care
- Delivery and all inpatient services for maternity care (includes complications)

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Coverage does not include services for surrogates, artificial insemination or in-vitro fertilization.

The company offers the My Health Essentials℠ Maternity Care program, a free maternity management program for expectant members. This program offers access to experienced maternity nurses, free educational materials and helpful advice. The staff of My Health Essentials works with the covered member's physician or OB/GYN to help identify and prevent any potential risks or complications.

Mental Health and Substance Use Disorder Services

Inpatient and outpatient facility and physician charges for mental health and substance use disorder services are covered just the same as any other illness or injury. Services for mental health or substance use disorder are to be covered as any other illness.

Prescription Drugs

Prescription Drugs are drugs and medications that, by federal law, require a prescription and can only be dispensed by a licensed pharmacy. Injectable insulin and diabetic supplies may also be also considered Prescription Drugs. In general, Generic Drugs are the lowest cost-sharing drug, followed by Preferred Drugs, then Non-preferred Drugs and finally Specialty Drugs as the highest cost-sharing drug.

Covered Drug List

A covered drug list is a list of prescription drugs approved by a group of network doctors and pharmacists who advise the company on pharmacy issues. The drugs are chosen because they are safe and effective, as well as cost-effective. The covered drug list has four coverage levels, called tiers.

- **Tier 1 (Generic)** – normally has the same active ingredient(s) as brand-name drugs but are not manufactured under a registered brand name or trademark. This tier includes most generic drugs and some over-the-counter drugs.
- **Tier 2 (Preferred)** – Drugs on this tier are most often brand drugs, sometimes referred to as "preferred" drugs, because they usually cost the member less than other brand drugs.
- **Tier 3 (Non-preferred)–** Drugs on this tier are most often brand drugs, sometimes referred to as "non-preferred" drugs because they usually cost the member more than other brand drugs. They may have generic equivalents.
- **Tier 4 (Specialty)** – are prescription drugs that treat a complex or chronic condition or that require special handling, such as refrigeration. They generally require complex clinical monitoring, training and expertise. They include but are not limited to:
    - Infusible drugs for acute and chronic illnesses
    - Injectable and self-injectable drugs for acute and chronic diseases
    - Biotechnology medicines
    - Specialty oral drugs or other dosage forms

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- Over-the-counter (OTC) drugs — do not require a prescription. BlueCross may cover specific classes of OTC drugs as prescription drugs. BlueCross will allow coverage for specific OTC drugs only when their use is required as part of a step therapy program. If an OTC drug is included in the member's coverage, the specific OTC drug class will be indicated on his or her schedule of benefits. The member must have a valid prescription written by a physician. Certain drug categories, such as weight loss and erectile dysfunction drugs, are excluded from coverage. Please see plan materials for a complete list of these exclusions.

The covered drug list may change anytime during the year. A common reason for a change is when a new generic becomes available for a preferred brand drug and the company removes the brand-name drug. A complete list of covered drugs can be found at www.SouthCarolinaBlues.com or www.MyChoiceSC.com.

Members can take advantage of these benefits by simply showing their ID card at network pharmacies any time they fill prescriptions. There are no claims to file when members use an in-network pharmacy.

Mail order — members may receive a 90-day supply of drugs through our mail order pharmacy.

The company will provide benefits for off-label use of prescription drugs that have not been approved by the FDA for the treatment of a specific type of cancer for which the drug was prescribed, provided the drug is recognized for treatment of that specific cancer in at least one standard reference compendium, or the drug is found to be safe and effective in formal clinical studies. These results must have been published in peer-reviewed professional medical journals.

If a physician prescribes a brand-name drug and there is an equivalent generic drug available (whether or not the physician allows substitution of the brand-name drug), the member must pay any difference between the cost of the generic drug and the higher cost of the brand-name drug.

Prior Authorization — Prior authorization requires the member's doctor to get prior approval for certain medications. See covered drug list for specific medications requiring Prior Authorization.

Quantity with time limits — limits the amount of medication a member may receive under his or her benefit in a specific timeframe. Medical necessity overrides (when medical necessity is documented by a member's physician and submitted to the company) are permitted for some drugs subject to quantity limits.

Step therapy — requires members to try lower-cost drugs before benefits are allowed for the higher-cost equivalent. For example, a member must have tried Omeprazole, Pantoprazole or Lansoprazole before benefits are allowed for for Nexium, Aciphex, or Dexilant.

Some other features of the prescription drug benefit are:

- Allows for a 31-day supply of medicine for each prescription or prescription refill at a retail pharmacy.

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- Allows for a 90-day retail prescription or prescription refill for maintenance drugs, subject to three retail copayments at a retail pharmacy (members may save by using mail order instead).
- Some drugs may require preauthorization from the company.
- Members will pay one copayment (usually the brand copayment) for each 30-day supply of lancets, test strips, needles and syringes for the treatment of diabetes.

Please note that no benefits are payable for:

- Drugs or medicine from a hospital, skilled nursing facility or doctor's office.
- Drugs or medicine available without a prescription, except insulin, even if a doctor writes a prescription (except for specific classes of OTC drugs indicated in the member's prescription drug list)
- Bandages, sundries and appliances
- Drugs that are used for or related to non-covered services or conditions, such as, but not limited to, weight control, obesity, cosmetic purposes.
- Drugs that are used for infertility.
- Drugs that require more than the number of days' supply allowed as shown in your Schedule of Benefits.
- Refills in excess of the number specified on your physician's prescription order.
- More than the recommended daily dosage as defined by the company.
- When not consistent with the diagnosis and treatment of an illness, injury or condition or that is excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care.
- When preauthorization if required, but not received.
- Drugs that requires step therapy when a step therapy program is not followed.

Rehabilitative and Habilitative Services and Devices

Habilitative services and/or devices are to help a person learn, keep, or improve skills and functional abilities that may not be developing normally. Rehabilitative services and/or devices are aimed at restoring lost skills or functions due to an injury or illness such as services provided in a skilled nursing facility.

Laboratory and Diagnostic Services

Benefits will be provided for procedures to identify the nature and/or extent of a condition or disease. We will reduce benefits for inpatient diagnostic services to the level of benefits for outpatient services when services could have been safely done on an outpatient basis. Lab services do not include: preconception testing, preconception genetic testing or any services related to infertility. Diagnostic services include, but are not limited to:

- Radiology, ultrasound and nuclear medicine

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- Laboratory and pathology
- ECG, EEG and other electronic diagnostic medical procedures and physiological medical procedures
- Endoscopies such as colonoscopy, proctoscopy and laparoscopy
- Surgical pathology — pathological examination of tissue removed surgically, by resection or biopsy. This does not include smear techniques
- High technology diagnostic services such as, but not limited to, MRIs, MRAs, PET scans and CT scans
- Cardiac catheterizations, and procedures performed with contrast or dye

Preventive and Wellness Services and Chronic Disease Management

The preventive services coverage requirements apply to the following general categories of preventive services, referred to as "Recommended Preventive Services," when furnished by an in-network provider or in-network primary care physician (PCP).

- Evidence-based services with a current "A" or "B" rating from the United States Preventive Services Task Force (USPSTF)
- Immunizations recommended for routine use by the Advisory Committee on Immunization Practices at the Centers for Disease Control and Prevention (CDC)
- For women, the preventive care and screening guidelines under development by the U.S. Department of Health and Human Services
- Child preventive care and screenings recommended by the Health Resources and Services Administration (HRSA)

Covered preventive services for adults are created using two resources: the USPSTF "A" and "B" recommendations and the immunizations recommended for routine use by the CDC.

The USPSTF researches a broad range of preventive health care services and develops recommendations and grades them according to a rating system.

The grades given by USPSTF are:

- A — Strongly Recommend
- B — Recommend
- C — No Recommendation For or Against
- D — Recommends Against
- I — Insufficient Evidence To Recommend For or Against

Only services with a grade of "A" or "B" are considered recommended preventive services in the context of health care reform, so they may not be subject to deductible or cost-sharing requirements. The other services with a grade of "C," "D" or "I" are not required to be covered.

The CDC monitors disease and public health concerns both within the United States and globally. Based on the recommendations provided by the Advisory Committee on

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Immunization Practices, the CDC provides a list of recommended immunizations for all age groups.

Recommended preventive services are covered only when provided by an in-network PCP only or at an in-network provider when services cannot be performed by a PCP or in a PCP setting. Services or requirements specific to men are in blue, services or requirements specific to women are in pink. Some services are subject to frequency and risk limitations.

Recommended Preventive Services for Adults

Preventive Services for Adults	
Counseling Risk Factor Reduction and Behavior Change Intervention Procedure (including alcohol misuse, depression, obesity, diet, sexually transmitted diseases, tobacco use — for those at risk)	All adults
Vaccines/Immunizations as Recommended by the Centers for Disease Control (CDC)	All adults
Aortic Aneurysm Screening	Men age 65 to 75 if ever smoked — one per lifetime
Breast Cancer Screening	Women age 40 and above — every 1–2 years
Cervical Cancer Screening	All women regardless of age
Chlamydia Infection Screening	All women regardless of age
Colorectal Cancer Screening (fecal occult blood testing annually; sigmoidoscopy every five years; colonoscopy every 10 years)	Adults age 50–75
Gonorrhea Screening	All women regardless of age
HIV Screening	All adults who are at risk
Lipid Disorder Screening (Cholesterol)	Adults age 20 and over who are at risk — two per year
Osteoporosis Screening	Women age 65 and over — every two years
Preventive Services for Adults	
Syphilis Infection Screening	All at-risk adults
Type 2 Diabetes Screening	All adults WITHOUT symptoms of or evidence

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	of possible diabetes complications
Prostate Screening Antigen (PSA)	Men as recommended by American Cancer Society
Contraceptives, Sterilization, and Patient Education	All women
Well-Woman Visits	All women – 2 per benefit period
Human Papillomavirus (HPV) Testing	Women age 30 and above – one every three years
Screening/Counseling for Interpersonal and Domestic Violence	All women

In addition to coverage for certain preventive services, the health care reform law allows for coverage of certain medications without cost-sharing requirements.

These medications are covered within the Caremark National Network Pharmacy, and the member must have a doctor's prescription for the covered preventive medication. Caremark is an independent company that provides the pharmacy network on behalf of BlueCross.

Preventive Medication for Adults	
Aspirin for the Prevention of Cardiovascular Disease (Generic Only)	Men age 45–79
	Women age 55–79
Folic Acid (Generic Only)	Women age 10–50

Recommended Preventive Services for Pregnant Women

Pregnant woman have additional Recommended Preventive Services. Covered preventive services for pregnant women are compiled from the same resources as the covered preventive services for adults plus one additional source: the U.S. Department of Health and Human Services (HHS). HHS provides guidelines for preventive care and screenings specifically for women with an emphasis on pregnancy, women who are planning to or may become pregnant, and breastfeeding mothers.

Preventive Services for Pregnant Women	
Bacteriuria Screening ("clean-catch" urine specimen)	All pregnant women
Hepatitis B Virus Infection Screening	All pregnant women
Iron Deficiency Anemia Screening	All pregnant women
Rh Incompatibility Screening	All pregnant women
Gestational Diabetes Screening	All pregnant women
Lactation Support/Counseling, and Supplies	All pregnant women

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Recommended Preventive Services for Children

These guidelines are based on the *Bright Futures* initiative of the American Association of Pediatrics.

Preventive Services for Children	
Preventive Medicine Examination/Evaluation/Management Procedure Usually administered as part of a wellvisit.	All children
Counseling Risk Factor Reduction and Behavior Change Intervention Procedure (including depression, obesity, diet, sexually transmitted diseases, tobacco use — for those at risk) Usually administered as part of a well visit	All children at risk
Vaccines/Immunizations as Recommended by the CDC	All children
Depression Screening	Ages 12 and over
HIV Screening	All at risk regardless of age
Syphilis Infection Screening	All at risk regardless of age
Visual Impairment Screening	Ages 5 and under

In addition to coverage for certain preventive services, the health care reform law allows for coverage of certain medications without cost-sharing requirements.

These medications are covered within the Caremark National Network Pharmacy and the member must have a doctor's prescription for the covered preventive medication.

Preventive Medication for Children	
Oral Fluoride (Generic Only)	Children age 0–5
Iron Supplement (Generic Only)	Children age 6–12
Folic Acid (Generic Only)	Females age 10 and over

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Pediatric Services

Pediatric Dental

Dental services are available for children through the end of the benefit year of their 19th birthday. All dental services over $100 must be preauthorized.

Classes of Coverage

- Class I — Preventive Care (two per year)
  - Checkups
  - Cleanings
  - Fluoride treatments (no age limit)
  - Space maintainers
  - Sealants (through age 13)
  - Emergency treatment for pain
  - X-rays
  - Lab tests
  - Other diagnostic exams
- Class II — Restorative Care
  - Simple and surgical teeth removal
  - Oral surgery
  - Anesthesia
  - Fillings
  - Treatments involving the bones, tissues and gums surrounding and supporting a tooth
  - Treatments involving the roots of teeth, including root canals.
- Class III — Major Restorative Care
  - Crowns, bridges dentures and other treatments for missing teeth (missing teeth prior to the effective date are not covered)
  - Inlays and denture and bridge repairs (existing dentures are not covered for 5 years from the date of the most recent replacement)
- Class IV — Orthodontic Benefits (12 month waiting period)
  Covers only medically necessary services and must be pre-authorized

Dental Network

Dental services must be performed at an in-network dentist. You can locate an in-network dental provider on www.SouthCarolinaBlues.com or www.MyChoiceSC.com.

Annual Dental Maximum

There is no annual dental maximum.

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Exclusions and Limitations

Here is a sample list of exclusions and limitations within the group dental policy. For a complete listing, please refer to an actual policy.

- Services or supplies that are not medically necessary.
- Charges for services or supplies that are investigational/experimental in nature.
- Services or supplies that you get before the effective date of coverage.
- Dental services received from a dental or medical department maintained by or on behalf of an Employer, a mutual benefit association, labor union, trustee or similar person or group.
- Services and supplies for which the dentist does not charge.
- Services or supplies paid by Workers' Compensation or similar legislation (if a Workers' Compensation claim is settled, treatment will be considered paid for by Workers' Compensation).
- Services and supplies primarily for cosmetic or aesthetic purposes, including personalization or characterization of dentures.
- Services and supplies for which a member is entitled to payment or benefits (whether or not any such payment or benefits have been applied for or paid) under the law of the United States (including Medicare), or any state or political subdivision thereof, except for Medicaid.
- Services or supplies related to chewing or bite problems, pain in the face, ears, jaws, or neck resulting from problems of the jaw joint(s), also known as temporo-mandibular joint disorders (TMJ). Benefits are limited to the x-rays and exam only.
- Services that a Dentist provides that are beyond the scope of his or her license.
- Dental services that cost more than they would have if no coverage had existed.
- Charges for a missed appointment or for filling out claim forms.
- Charges for visits at home or in the hospital, except in connection with emergency care.
- Dental care not specifically listed in the Schedule of Benefits.
- Any service or supply provided by a member of the patient's family or by the patient, including the dispensing of drugs. This means the spouse, parent, grandparent, brother, sister, child or spouse's parent.
- Illness contracted or injury sustained as a result of declared or undeclared war or any act of war, or while in the military service or unit auxiliary.
- Services related to teeth that were missing before the effective date of a member's coverage.
- Services or supplies that do not meet accepted standards of dental practice.
- Claims submitted after the time limit for filing claims has been exceeded.
- Replacement of a denture that could have been repaired or extended.

Pediatric Vision

Vision services are available for children through the end of the benefit year of their 19th birthday. Members are eligible for one routine eye exam and one pair of frames and lenses per benefit period. Benefits are payable for contact lenses only when medically necessary.

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