FirstChoice VIP CARE®
by Select Health of South Carolina

2026 Summary of Benefits

South Carolina (SC01)

Service Area: Abbeville, Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Cherokee, Chester, Chesterfield, Clarendon, Colleton, Darlington, Dillon, Dorchester, Edgefield, Fairfield, Florence, Georgetown, Greenville, Greenwood, Hampton, Horry, Jasper, Kershaw,Lancaster, Laurens, Lee, Lexington, Marion, Marlboro, McCormick, Newberry, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Sumter, Union, Williamsburg, and York counties.

H4739_001_124952_M_Approved_09162025 MED-MLT_254637500-3

First Choice VIP Care (HMO D-SNP) | 2026 Summary of Benefits

Introduction

This document is a brief summary of the benefits and services covered by First Choice VIP Care. It includes answers to frequently asked questions, important contact information, an overview of benefits and services offered, and information about your rights as a member of First Choice VIP Care. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Disclaimers

This is a summary of health services covered by First Choice VIP Care for 2026. This is only a summary. Please read the *Member Handbook* for the full list of benefits. To get a copy of the *Member Handbook*, call Member Services at the number at the bottom of the page. You can also find the *Member Handbook* at www.firstchoicevipcare.com.

❖ First Choice VIP Care is an HMO D-SNP plan with a Medicare contract and a contract with the South Carolina Healthy Connections Medicaid program. Enrollment in First Choice VIP Care depends on contract renewal.

❖ For more information about Medicare, you can read the *Medicare & You* handbook. It has a summary of Medicare benefits, rights, and protections, and answers to the most frequently asked questions about Medicare. You can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

❖ For more information about First Choice VIP Care, you can check the South Carolina Healthy Connections Medicaid program website www.scdhhs.gov/resources/health-managed-care-plans/dual-special-needs-plans or call 1-888-549-0820 or TTY: 1-888-842-3620, Monday through Friday from 8 a.m. to 6 p.m. Eastern time. You can also call the Long-Term Care Ombudsman from the South Carolina Department of Aging at 1-844-477-4632, TTY: 711, Monday through Friday, 8 a.m. to 6 p.m. Eastern time. The Ombudsman is for people of any age who have both Healthy Connections Medicaid and Medicare. South Carolina Department on Aging (SCDOA) can be reached at 1-800-868-9095 (TTY 711), Monday through Friday, 8:30 a.m. to 5 p.m.

❖ This document is available in Spanish.

❖ You can get this document for free in other formats, such as large print, braille, or audio. Call Member Services at the numbers in the footer of this document. The call is free.

❖ ATENCIÓN: Si Habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicios al Miembro de First Choice VIP Care al 1-888-996-0499 (TTY 711), octubre 1 a marzo 31, de 8 a.m. a 8 p.m. De abril 1 a septiembre 30, de 8 a.m. a 8 p.m, los siete dias de la semana. La llamada es gratuita.

You can request to get this document, now and in the future, in a language other than English or in another format simply by calling Member Services at the number at the bottom of the page. We'll also ask for your preference during our Welcome Call and later in the year, when you contact the plan. The plan will store your request and continue to send future documents in this requested language or format unless you ask us to cancel or change the request. You can cancel or change your request at any time, simply by calling Member Services. The calls are free.

B. Frequently asked questions (FAQ)

Frequently Asked Questions	Answers
What's a HIDE D-SNP?	Our plan is a highly integrated dual eligible (HIDE) D-SNP, also called an "integrated D-SNP." A HIDE D-SNP is a health plan that contracts with both Medicare and Healthy Connections Medicaid to provide benefits of both programs to enrollees. It's for people with both Medicare and Healthy Connections Medicaid. A HIDE D-SNP is an organization made up of doctors, hospitals, pharmacies, providers of behavioral health (mental health) services, and other providers. It also has care coordinators to help you manage all your providers and services. They all work together to provide the care you need.
Will I get the same Medicare and Medicaid benefits in First Choice VIP Care that I get now?	You'll get most of your covered Medicare and Healthy Connections Medicaid benefits directly from First Choice VIP Care. You'll work with a team of providers who will help determine what services will best meet your needs. This means that some of the services you get now may change based on your needs and your doctor and care coordinator's assessment. You may also get other benefits outside of your health plan, the same way you do now, outside of the plan. When you enroll in First Choice VIP Care, you and your care coordinator will work together to develop a care plan to address your health and support needs, reflecting your personal preferences and goals. If you're taking any Medicare Part D drugs that First Choice VIP Care doesn't normally cover, you can get a temporary supply, and we'll help you to transition to another drug or get an exception for First Choice VIP Care to cover your drug if medically necessary. For more information, call Member Services at the numbers in the footer of this document.

Frequently Asked Questions	Answers
Can I use the same doctors I use now?	This is often the case. If your providers (including doctors, hospitals, therapists, pharmacies, and other health care providers) work with First Choice VIP Care and have a contract with us, you can keep going to them. • Providers with an agreement with us are "in-network." Network providers participate in our plan. That means they accept members of our plan and provide services our plan covers. **You must use the providers in First Choice VIP Care's network.** If you use providers or pharmacies that aren't in our network, the plan may not pay for these services or drugs. • If you need urgent or emergency care or out-of-area dialysis services, you can use providers outside of First Choice VIP Care's plan. If First Choice VIP Care is new for you, you can continue using the doctors you use now for 90 days after you first enroll, even if they're out-of-network. If you need to continue using your out-of-network providers after your first 90 days in our plan, we'll only cover that care if the provider enters a single case agreement with us. If you're getting ongoing treatment from an out-of-network provider and think they may need a single case agreement in order to keep treating you, contact your care coordinator at the number listed in the footer of this document. To find out if your providers are in the plan's network, call Member Services at the numbers in the footer of this document or read First Choice VIP Care's *Provider and Pharmacy Directory* on the plan's website at www.firstchoicevipcare.com. If First Choice VIP Care is new for you, we'll work with you to develop a care plan to address your needs.
What's a First Choice VIP Care care coordinator?	A First Choice VIP Care care coordinator is the main person for you to contact. This person helps to manage all your providers and services and make sure you get what you need.
What happens if I need a service but no one in First Choice VIP Care's network can provide it?	Most services will be provided by our network providers. If you need a service that can't be provided within our network, First Choice VIP Care will pay for the cost of an out-of-network provider.

Frequently Asked Questions	Answers
Where's First Choice VIP Care available?	The service area for this plan includes: Abbeville, Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Cherokee, Chester, Chesterfield, Clarendon, Colleton, Darlington, Dillon, Dorchester, Edgefield, Fairfield, Florence, Georgetown, Greenville, Greenwood, Hampton, Horry, Jasper, Kershaw, Lancaster, Laurens, Lee, Lexington, Marion, Marlboro, McCormick, Newberry, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Sumter, Union, Williamsburg, York Counties, South Carolina. You must live in one of these areas to join the plan.
What's prior authorization?	Prior authorization means an approval from First Choice VIP Care to seek services outside of our network or to get services not routinely covered by our network **before** you get the services. First Choice VIP Care may not cover the service, procedure, item, or drug if you don't get prior authorization. **If you need urgent or emergency care or out-of-area dialysis services, you don't need to get prior authorization first**. First Choice VIP Care can provide you or your provider with a list of services or procedures that require you to get prior authorization from First Choice VIP Care before the service is provided. Refer to **Chapter 3**, of the *Member Handbook* to learn more about prior authorization. Refer to the Benefits Chart in **Chapter 4** of the *Member Handbook* to learn which services require prior authorization. If you have questions about whether prior authorization is required for specific services, procedures, items, or drugs, call Member Services at the numbers in the footer of this document for help.
What's a referral?	A referral means that your primary care provider (PCP) must give you approval before you can use someone who isn't your PCP or use other providers in the plan's network. If you don't get approval, First Choice VIP Care may not cover the services, and you may be billed for these services. A referral is different than a prior authorization. You don't need a referral to use some specialists, such as women's health specialists. Refer to **Chapter 3**, of the *Member Handbook* to learn more about when you'll need to get a referral from your PCP. First Choice VIP Care can provide you with a list of services that require you to get a referral from your care team before the service is provided.

Frequently Asked Questions	Answers
Do I pay a monthly amount (also called a premium) under First Choice VIP Care?	No. Because you have Medicaid you won't pay any monthly premiums, including your Medicare Part B premium, for your health coverage.
Do I pay a deductible as a member of First Choice VIP Care?	No. You don't pay deductibles in First Choice VIP Care.
What's the maximum out-of-pocket amount that I'll pay for medical services as a member of First Choice VIP Care?	There's no cost sharing for medical services in First Choice VIP Care, so your annual out-of-pocket costs will be $0.

C. List of covered services

The following table is a quick overview of what services you may need, your costs, and rules about the benefits.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hospital care	Inpatient hospital stay	$0	Except in an emergency, your health care provider must tell the plan of your hospital admission. Prior authorization is required.
	Outpatient hospital services, including observation	$0	Prior authorization is required for outpatient hospital services, excluding observation.
	Ambulatory surgical center (ASC) services	$0	Prior authorization is required.
	Doctor or surgeon care	$0	Prior authorization is required for surgery in an inpatient or outpatient hospital setting.
You want a doctor	Visits to treat an injury or illness	$0	
	Care to keep you from getting sick, such as flu shots and screenings to check for cancer	$0	
	Wellness visits, such as a physical	$0	
	“Welcome to Medicare” (preventive visit one time only)	$0	
	Specialist care	$0	

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need emergency care	Emergency room services	$0	Emergency room services are provided without prior authorization requirements, even if the services are provided out of network.
	Urgent care	$0	Urgent care services are provided without prior authorization requirements, even if the services are provided out of network.
You need medical tests	Diagnostic radiology services (for example, X-rays or other imaging services, such as CAT scans or MRIs)	$0	Not all x-rays, outpatient diagnostic/therapeutic/radiological procedures, and tests will require authorization. Ask your provider to call the plan to confirm if an authorization is required.
You need medical tests	Lab tests and diagnostic procedures, such as blood work	$0	Not all lab services will require authorization. Ask your provider to call the plan to confirm if an authorization is required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hearing/auditory services	Hearing screenings	$0	
	Hearing aids	$0	Up to $2,500 toward the cost of two non-implantable TruHearing-branded Advanced hearing aids every three years (limit 1 hearing aid per ear). After the plan-paid benefit, you are responsible for the remaining costs. You must see a TruHearing provider to use this benefit. **Hearing aid purchase includes:** • First 12 months of follow-up provider visits • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models
	Routine Hearing exam	$0	In addition to the Medicare-covered hearing benefit, the plan also covers one additional routine hearing exam.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need dental care (Continued on next page)	Emergency dental procedures by oral surgeons	$0	Prior authorization is required.
	Dental procedures related to organ transplants, cancer, joint replacement, heart valve replacement, and trauma	$0	Prior authorization is required.
	Preventive and Comprehensive dental	$0	**Preventive dental:** Oral exams: 1 every 6 months Cleaning: 1 every 6 months Fluoride treatment: 1 every 6 months Dental x-rays – 1 full mouth radiograph and 1 panoramic radiograph every 5 years and up to 6 bitewing or periapical radiographs every year. **Comprehensive dental:** Up to a $3,000 limit every year for: Minor restorations (fillings). Endodontics (1 per tooth per lifetime) * Periodontics Dentures (1 per arch every 5 years) * Denture repair and reline (1 per year) * Mini implant * Prosthodontics * Oral and Maxillofacial surgery Extractions (1 per tooth per lifetime) *

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need dental care (continued)			*Prior authorization may be required. Other service limitations apply. Read the *Member Handbook* for more information on these benefits.
You need eye care	Treatment for eye injuries or diseases	$0	
	Initial replacement of lens due to cataract surgery	$0	Prior authorization is required.
	Routine vision	$0	One routine eye exam every year, excluding contact lens exam and fitting services. Up to a $355 allowance for one pair of eyeglasses (lenses and frames) or one pair of contact lenses is covered every year. You must receive your care from an in-network provider. We will only pay for covered vision services if you go to an in-network vision provider. In most cases, you will have to pay for care that you receive from an out-of-network provider.
You need behavioral health services (continued on next page)	Behavioral health services	$0	Referral required for Healthy Connections Medicaid-covered outpatient mental health services. Referral required for the Institution for Mental Disease

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need behavioral health services (continued)			Services for individuals 65 years or older.
	Inpatient and outpatient care and community-based services for people who need behavioral health services	$0	Referral required for Healthy Connections Medicaid-covered outpatient mental health services. Referral required for Institution for Mental Disease Services for individuals 65 years or older.
You need substance use disorder services	Substance use disorder services	$0	Covered services include, but are not limited to: • Psychotherapy • Patient education • Follow-up care after you leave the hospital • Prescription drugs during a hospital stay or injected at a doctor's office. • Preventive screening and counseling Prior authorization required. Not all outpatient substance abuse services will require authorization. Have your provider call the plan to confirm if an authorization is required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need a place to live with people available to help you	Skilled nursing care	$0	Medicare-covered stays (for example, rehabilitation) require a PA, while Healthy Connections Medicaid-covered stays (for example, long term skilled nursing facility (SNF) stays) only require a referral. Prior authorization is required for Medicare-covered SNF services.
	Nursing home care	$0	
	Adult Foster Care and Group Adult Foster Care	$0	
You need therapy after a stroke or accident	Occupational, physical, or speech therapy	$0	Prior authorization is required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help getting to health services	Ambulance services	$0	Prior authorization may be required.
	Emergency transportation	$0	
	Transportation to medical appointments and services	$0	24 one-way trips every year to plan-approved locations (e.g. doctor's office, pharmacy, and hospital). May consist of a car, shuttle, or van service, depending on appropriateness for the situation and the member's needs. Rides must be scheduled at least one business day in advance, except in special circumstances. Limit of 50 miles per one-way trip. Routine non-emergent medical transport (NEMT) services are covered for Medicaid-covered services.
You need drugs to treat your illness or condition (continued on next page)	Medicare Part B drugs	$0 to 20% coinsurance	$0 for preferred Part B drugs Part B drugs include drugs given by your doctor in their office, some oral cancer drugs, and some drugs used with certain medical equipment. Read the *Member Handbook* for more information on these drugs. Non-preferred brands and all continuous glucose monitors

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued on next page)			will require a prior authorization and have a 20% co-insurance (until you reach the Maximum out of pocket (MOOP limit). Preferred brands have a $0 copay.
	Medicare Part D drugs Tier 1: Preferred Generic Tier 2: Generic Tier 3: Preferred Brand Tier 4: Non-Preferred Drug Tier 5: Specialty Tier 6: Select Care Drugs	**Retail Pharmacy** for up to a 100-day supply. Deductible- $0 or $615** Tier 1-5: $0 - $12.65 copay* or 25% coinsurance** Tier 6: $0 copay *Cost sharing is based on the level of "Extra Help" the member receives. **Deductible and coinsurance may apply for members without “Extra Help.” **Mail Order** for a 61 to 100-day supply: Tier 1-5: $0 - $12.65 copay* or 25% coinsurance (not to exceed what the member pays for one month). * Tier 6: $0 copay	There may be limitations on the types of drugs covered. Please refer to First Choice VIP Care’s *List of Covered Drugs* (*Drug List*) for more information. Once you or others, on your behalf, pay $2,100, you’ve reached the catastrophic coverage stage, and you pay $0 for all your Medicare drugs. Read the *Member Handbook* for more information on this stage. Mail-order (up to 100-day) supplies are available for many drugs at all network retail locations for the same $0 cost as a 30-day supply. Mail-order pharmacies allow fills of a 61–100-day supply at the same cost as a 30-day supply.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)		Copays for drugs may vary based on the level of Extra Help you get. Please contact the plan for more details.	
You need help with everyday expenses (continued on next page)	Over-the-counter (OTC) drugs Special Supplemental Benefits for the Chronically Ill (SSBCI)	$0	Up to $106 allowance per quarter to spend on eligible OTC items such as vitamins, pain relievers, cold remedies, and more. Funds are loaded to a plan-issued debit card each quarter. If a member qualifies, the OTC allowance can be combined with the SSBCI benefits. This credit can be used for: • Healthy foods • General Supports for living (e.g., rent, mortgage, utilities) • Pest Control In order to qualify for SSBCI, members must have at least one of the following chronic health conditions: cardiovascular disorders, chronic and disabling mental health conditions, chronic gastrointestinal disease limited to end stage liver disease), chronic lung disorders (limited to chronic obstructive pulmonary

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help with everyday expenses (continued)			disorder), congestive heart failure, connective tissue disease, dementia, diabetes mellitus, overweight, obesity, & metabolic syndrome, and stroke. In addition, the condition must be life-threatening or greatly limit the overall health or function of the member; the member must be at high risk of hospitalization or other adverse health outcomes; and the member must require intensive care coordination. The plan will review objective criteria to determine a member's eligibility. For more information or to check eligibility, members should contact the plan. Unused amounts expire at the end of each month or upon disenrollment from the plan.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help getting better or have special health needs	Rehabilitation services	$0	Prior authorization is required for cardiac and pulmonary services.
	Medical equipment for home care	$0	Prior authorization is required for some medical equipment for home care. Have your provider call the plan to confirm if authorization is required.
	Dialysis services	$0	
You need foot care	Podiatry services	$0	Nine routine foot care visits every year.
	Orthotic services	$0	Prior authorization may be required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need durable medical equipment (DME) **Note:** This isn't a complete list of covered DME. For a complete list, contact Member Services or refer to **Chapter 4** of the *Member Handbook*.	Wheelchairs, crutches, and walkers	$0	Prior authorization may be required.
	Nebulizers	$0	Prior authorization may be required.
	Oxygen equipment and supplies	$0	Prior authorization may be required.
Additional services (continued on next page)	Chiropractic services	$0	20 combined visits covered per year, with acupuncture.
	Diabetes supplies and services	$0	Preferred brands have a $0 copay. Non-preferred brands and all continuous glucose monitors will require prior authorization and have a 20% co-insurance (until you reach the Maximum out-of-pocket limit).
	Prosthetic services	$0	Prior authorization is required for rental and purchased Medicare-covered prosthetics and medical supplies.
	Radiation therapy	$0	
	Services to help manage your disease	$0	
	Personal Emergency Response System (PERS)	$0	Personal Emergency Response System (PERS) is a medical alert monitoring system that provides 24/7

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional services (continued)			access to help at the push of a button. We offer multiple styles, including a mobile-enabled wearable device. Benefit limited to one device per year.
	Silver Sneakers	$0	SilverSneakers® is a free fitness benefit that includes access to participating SilverSneakers® fitness facilities and services.

The above summary of benefits is provided for informational purposes only and isn't a complete list of benefits. For a complete list and more information about your benefits, you can read the First Choice VIP Care *Member Handbook*. If you don't have a *Member Handbook*, call First Choice VIP Care Member Services at the numbers in the footer of this document to get one. If you have questions, you can also call Member Services or visit www.firstchoicevipcare.com.

D. Benefits covered outside of First Choice VIP Care

There are some services that you can get that aren't covered by First Choice VIP Care but are covered by Medicare, Medicaid, or a State or county agency. This isn't a complete list. Call Member Services at the numbers in the footer of this document to find out about these services.

Other services covered by Medicare, Medicaid, or a State Agency	Your costs
Certain hospice care services covered outside of First Choice VIP Care	$0
Dental services • Diagnostics (oral evaluation and x-rays) • Preventive care (annual cleaning)	$0
Long-Term Services and Supports (LTSS) are help for people who need assistance to do everyday tasks like bathing, toileting, getting dressed, making food, and taking medicine. Most of these services are provided at your home or in your community but could be provided in a nursing home or hospital. These services are provided through programs called Healthy Connections Medicaid waivers. Contact your care coordinator for more information about getting LTSS and referrals to an appropriate waiver.	$0
Non-emergency medical transportation	$0
Psychosocial rehabilitation	$0
Targeted case management	$0

E. Services that First Choice VIP Care, Medicare, and Medicaid don't cover

This isn't a complete list. Call Member Services at the numbers in the footer of this document to find out about other excluded services.

Services First Choice VIP Care, Medicare, and Medicaid don't cover	
Certain visual procedures such as LASIK	Elective or voluntary enhancement procedures or services
Services not considered "reasonable and necessary"	Services provided to veterans in a VA facility
Cosmetic surgery or procedures	Elective or voluntary enhancement procedures or services.
Naturopath services	

F. Your rights as a member of the plan

As a member of First Choice VIP Care, you have certain rights. You can exercise these rights without being punished. You can also use these rights without losing your health care services. We'll tell you about your rights at least once a year. For more information on your rights, please read the *Member Handbook*. Your rights include, but aren't limited to, the following:

- **You have a right to respect, fairness, and dignity.** This includes the right to:
  - Get covered services without concern about medical condition, health status, receipt of health services, claims experience, medical history, disability (including mental impairment), marital status, age, sex (including sex stereotypes and gender identity) sexual orientation, national origin, race, color, religion, creed, or public assistance
  - Get information in other languages and formats (for example, large print, braille, or audio) free of charge
  - Be free from any form of physical restraint or seclusion

- **You have the right to get information about your health care.** This includes information on treatment and your treatment options. This information should be in a language and format you can understand. This includes the right to get information on:
  - Description of the services we cover
  - How to get services
  - How much services will cost you
  - Names of health care providers and care coordinator

- **You have the right to make decisions about your care, including refusing treatment.** This includes the right to:
  - Choose a primary care provider (PCP) and change your PCP at any time during the year
  - Use a women's health care provider without a referral
  - Get your covered services and drugs quickly
  - Know about all treatment options, no matter what they cost or whether they're covered
  - Refuse treatment, even if your health care provider advises against it
  - Stop taking medicine, even if your health care provider advises against it
  - Ask for a second opinion. First Choice VIP Care will pay for the cost of your second opinion visit
  - Make your health care wishes known in an advance directive
- **You have the right to timely access to care that doesn't have any communication or physical access barriers.** This includes the right to:
  - Get timely medical care
  - Get in and out of a health care provider's office. This means barrier-free access for people with disabilities, in accordance with the Americans with Disabilities Act
  - Have interpreters to help with communication with your health care providers and your health plan
- **You have the right to seek emergency and urgent care when you need it.** This means you have the right to:
  - Get emergency services without prior authorization in an emergency
  - Use an out-of-network urgent or emergency care provider, when necessary
- **You have a right to confidentiality and privacy.** This includes the right to:
  - Ask for and get a copy of your medical records in a way that you can understand and to ask for your records to be changed or corrected
  - Have your personal health information kept private
  - Have privacy during treatment

- **You have the right to make complaints about your covered services or care.** This includes the right to:
  - File a complaint or grievance against us or our providers
  - File a complaint with the South Carolina Department of Public Health at www.dph.sc.gov/professionals/healthcare-quality/file-complaint or by phone: 1-800-922-6735 and TTY: 711.
  - Appeal certain decisions made by Healthy Connections Medicaid, our plan, or our providers. The Healthy Connections website is www.scdhhs.gov
  - Ask for a state fair hearing
  - Get a detailed reason for why services were denied

For more information about your rights, you can read the *Member Handbook*. If you have questions, you can call First Choice VIP Care Member Services at the numbers in the footer of this document.

You can also call the special Long Term Care Ombudsman from the South Carolina Department of Aging at 1-844-477-4632, TTY: 711, Monday through Friday, 8 a.m. to 6 p.m. Eastern time. The Ombudsman is for people of any age who have both Healthy Connections Medicaid and Medicare.

G. How to file a complaint or appeal a denied service

If you have a complaint or think First Choice VIP Care should cover something we denied, call Member Services at the numbers in the footer of this document. You may be able to appeal our decision.

For questions about complaints and appeals, you can read **Chapter 9** of the *Member Handbook*. You can also call First Choice VIP Care Member Services at the numbers in the footer of this document.

You can also put your complaint in writing. Please include the following:

- Your name and address
- Your Medicare number (you can find this number on your red, white, and blue Medicare card)
- Your Member Identification Number (you can find this on your Member ID card)
- The reason for your complaint
- Any additional information, including dates, times, persons, and places involved.

Mail to:

First Choice VIP Care
Attn: Customer Experience, Grievances, and Complaints
P.O. Box 7140
London, KY 40742

H. What to do if you suspect fraud

Most health care professionals and organizations that provide services are honest. Unfortunately, there may be some who are dishonest.

If you think a doctor, hospital or other pharmacy is doing something wrong, please contact us.

- Call us at First Choice VIP Care Member Services. Phone numbers are the numbers in the footer of this document.

- Or, call the Healthy Connections Medicaid Fraud Hotline at 1-888-364-3224. TTY users may call 711. You can also email fraudres@scdhhs.gov.

- Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users may call 1-877-486-2048. You can call these numbers for free.

If you have general questions or questions about our plan, services, service area, billing, or Member ID Cards, please call First Choice VIP Care Member Services:

1-888-996-0499
Calls to this number are free. October 1 – March 31: 8 a.m. - 8 p.m., seven days a week. April 1 – September 30: 8 a.m. - 8 p.m., Monday through Friday.
Member Services also has free language interpreter services available for non-English speakers.

711
Calls to this number are free. October 1 – March 31: 8 a.m. - 8 p.m., seven days a week. April 1 – September 30: 8 a.m. - 8 p.m., Monday through Friday.

124952 (8/25)

FirstChoice VIP CARE®
by Select Health of South Carolina

www.firstchoicevipcare.com

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