BlueChoice HealthPlan South Carolina

An independent licensee of the Blue Cross and Blue Shield Association

Non-Grandfathered

Schedule of Benefits
BlueChoice Advantage Plus HDHP[SM]
Rogers Townsend

In order to receive In-Network benefits, all services must be provided by a BlueChoice HealthPlan Participating Provider. This applies to each individual service unless otherwise noted. All admissions must be authorized by BlueChoice HealthPlan in order to be covered. Benefits are subject to all terms, conditions, limitations, and exclusions outlined in the Contract.

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Deductible per Benefit Period		
Individual Coverage	$2,700	$3,500
Family Coverage	$5,400	$7,000
Maximum Out-of-Pocket per Benefit Period (includes deductible, coinsurance and all copays) (Embedded MOOP: All family members can contribute with no one member contributing more than the Individual amount.)		
Individual Coverage	$2,700	$10,000
Family Coverage	$5,400	$20,000

Services other than Mental Health and Substance Use Disorders

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS (Member must pay balance of Provider's Charge)
Physician Care		
Office services	Deductible, then 0%	Deductible, then 40%
Mandated Preventive Care	$0	Not Covered
Other Routine Services	(Not subject to deductible or copayment)	
GYN Exam (2 per Benefit Period) Routine Screening Mammogram Routine Screening Colonoscopy	$0	Deductible, then 40%
Hospital/Facility Services	**(Authorization required)**	**(Authorization required)**
Inpatient Admission (including maternity)	Deductible, then 0%	Deductible, then 40%
Skilled Nursing Facility	Deductible, then 0%	Deductible, then 40%
Long-term Acute Care Facility	Deductible, then 0%	Deductible, then 40%

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Services other than Mental Health and Substance Use Disorders

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS (Member must pay balance of Provider's Charge)
Outpatient/Ambulatory Care Facilities		
All services (including maternity)	Deductible, then 0%	Deductible, then 40%
Emergency room services	Deductible, then 0%	Same as In-Network
Ambulatory Surgical Center	Deductible, then 0%	Deductible, then 40%
Urgent care	Deductible, then 0%	Deductible, then 40%
Prescription Medicine Certain Prescription Medicine may require prior authorization or have dosage limits	Deductible, then 0%	Not Covered
Specialty Pharmaceuticals	Deductible, then 0%	Not Covered
Other Services		
Ambulance	Deductible, then 0%	Deductible, then 40%
Behavioral Therapy (ABA) for Autism Spectrum Disorder	Deductible, then 0%	Not Covered
Dental Services due to accidental injury	Deductible, then 0%	Deductible, then 40%
Durable Medical Equipment (DME)	Deductible, then 0%	Deductible, then 40%
Home Health	Deductible, then 0%	Deductible, then 40%
Hospice	Deductible, then 0%	Deductible, then 40%
Initial Prosthetic Appliances	Deductible, then 0%	Deductible, then 40%
Medical Supplies	Deductible, then 0%	Deductible, then 40%
Occupational Therapy	Deductible, then 0%	Deductible, then 40%
Outpatient Private Duty Nursing	Deductible, then 0%	Deductible, then 40%
Physical Therapy	Deductible, then 0%	Deductible, then 40%
Speech Therapy	Deductible, then 0%	Deductible, then 40%
Chiropractic Services		
Manipulation	Deductible, then 0%	Not Covered
All Other Services	Deductible, then 0%	Not Covered

Covered Transplants will be treated the same as any other medical condition. Services must be provided at a BlueChoice HealthPlan participating facility or a Blues Distinction for Transplant designated facility.

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Mental Health & Substance Use Disorders

(Companion Benefit Alternatives, Inc. (CBA) must authorize these services in advance. On behalf of BlueChoice HealthPlan, CBA manages behavioral health and substance abuse benefits for our members and their dependents. CBA is a separate company. Call CBA at 1-800-868-1032)

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS (Member must pay balance of Provider's Charge)
Inpatient Hospital Facility Services	Deductible, then 0%	Deductible, then 40%
Inpatient Physician Services	Deductible, then 0%	Deductible, then 40%
Outpatient Facility Institutional Services	Deductible, then 0%	Deductible, then 40%
Outpatient Facility Professional Services	Deductible, then 0%	Deductible, then 40%
Office Professional Services (does not require prior authorization)	Deductible, then 0%	Deductible, then 40%
Urgent Care (does not require prior authorization)	Deductible, then 0%	Deductible, then 40%

Benefits not listed above will be covered the same as "Services other than Mental Health and Substance Use Disorders"

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MAXIMUMS	
Occupational Therapy	20 visits per Benefit Period
Outpatient Private Duty Nursing	60 visits per Benefit Period
Physical Therapy	20 visits per Benefit Period
Skilled Nursing Facility	120 days per Benefit Period
Speech Therapy	20 visits per Benefit Period
Benefit Period	Contract Year

The following benefits are covered outside of the BlueChoice Advantage Plus medical benefits.

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BENEFITS	MEMBER PAYS
Employee Assistance Program (EAP Services)	
Individual & Family Counseling (visits 1-6)	$0
Life Management Services (6 visits)	$0
Benefits are provided under an agreement between First Sun EAP and the Employer. First Sun EAP is a separate company that does not offer BlueChoice HealthPlan products. These services are offered by First Sun EAP, not BlueChoice HealthPlan. BlueChoice HealthPlan has no responsibility for these services. For services, please call First Sun EAP at 1-800-968-8143. First Sun EAP staff are available 24 hours a day, 7 days a week.	

- Nurseline
- NetEffect AGR
- Personal Health Assessment