BlueChoice HealthPlan South Carolina

An independent licensee of the Blue Cross and Blue Shield Association

Non-Grandfathered

Schedule of Benefits
BlueChoice Advantage Plus℠
Boyd Management Inc. – Low Plan

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		
Per Member	$3,000	$6,000 per individual
Per Family (All family Members can contribute with no one Member contributing more than the individual deductible amount.)	$6,000	
Maximum Out-of-Pocket per Benefit Period (includes deductible, coinsurance and all copays)		
Per Member	$6,350	$13,000 per individual
Per Family	$12,700	

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)
Primary Care		
Office services	$30 per visit	Deductible, then 50%
Mandated Preventive Care	$0	Not Covered
Specialty Care		
Office services	$60 per visit	Deductible, then 50%
Hospital services (includes inpatient, outpatient & ambulatory care services)	Deductible, then 30%	Deductible, then 50%
Emergency room care	Deductible, then 30%	Deductible, then 30%
Other Routine Care		
GYN Exam – 2 per Benefit Period	$0	Deductible, then 50%
Routine Screening Mammogram	$0	Deductible, then 50%
Routine Screening Colonoscopy	$0	Deductible, then 50%
Maternity Care		
Routine Maternity Physician Services (no additional copay for ongoing routine care)	Deductible, then 30%	Deductible, then 50%

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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)
Inpatient Hospital/Facility Services (Authorization required)			
Admission (including maternity)	Deductible, then 30%		Deductible, then 50%
Skilled Nursing Facility	Deductible, then 30%		Deductible, then 50%
Long-term Acute Care	Deductible, then 30%		Deductible, then 50%
Outpatient/Ambulatory Care Facilities			
All outpatient services (including maternity)	Deductible, then 30%		Deductible, then 50%
Emergency room services	$125 per visit, then 30%		Same as In-Network
Ambulatory Surgical Center	$60 per visit		Deductible, then 50%
Urgent care	$30 per visit		Deductible, then 50%
Prescription Medicine	Retail (up to a 31-day supply)	Mail Order (up to a 90-day supply)	Covered only at a Participating Pharmacy
Tier 1	$8	$20.00	
Tier 2	$25	$62.50	
Tier 3	$45	$112.50	
Tier 4	$70	$175.00	
No max per Benefit Period	You will have to pay more if you select a non-generic drug instead of its less-expensive Covered generic drug (or Covered over the counter) alternative.		
Tier 5	$125	$312.50	Not Covered
Tier 6	$175	$437.50	
No max per Benefit Period • Specialty medications are not available through the mail order program for a 90-day supply. This only applies to generic or brand drugs in these tiers.	Not Covered: Drugs designated as excluded on the Prescription Drug List.		

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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)
Other Services		
Ambulance	Deductible, then 30%	Deductible, then 50%
Behavioral Therapy (ABA) for Autism Spectrum Disorder	Deductible, then 30%	Not Covered
Dental Services due to accidental injury	Deductible, then 30%	Not Covered
Durable Medical Equipment (DME)	Deductible, then 30%	Not Covered
Home Health	Deductible, then 30%	Deductible, then 50%
Hospice	Deductible, then 30%	Deductible, then 50%
Initial Prosthetic Appliances	Deductible, then 30%	Deductible, then 50%
Medical Supplies	Deductible, then 30%	Deductible, then 50%
Occupational Therapy	Deductible, then 30%	Not Covered
Outpatient Private Duty Nursing	Deductible, then 30%	Deductible, then 50%
Physical Therapy	Deductible, then 30%	Not Covered
Speech Therapy	Deductible, then 30%	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 30%	Deductible, then 50%
Inpatient Physician Services	Deductible, then 30%	Deductible, then 50%
Outpatient Facility Institutional Services	Deductible, then 30%	Deductible, then 50%
Outpatient Facility Professional Services	Deductible, then 30%	Deductible, then 50%
Office Professional Services (does not require prior authorization)	$30 per visit	Deductible, then 50%
Urgent Care (does not require prior authorization)	Deductible, then 30%	Deductible, then 50%

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

BENEFITS	MEMBER PAYS
Routine Vision Care - Physicians EyeCare Network (PEN) Providers Only (Refer to Provider Directory)	**(Authorization not required)**
One routine eye exam or one exam for contact lenses per Benefit Period	$0
One standard contact lens fitting per Benefit Period	$45
One pair of eyewear from a designated selection every other Benefit Period	$0
Please consult your PEN Provider for information on discounts for which you may be eligible if you elect to receive eyewear/contact lenses outside the standard designated selection. **(For Members outside of the South Carolina service area, $71 will be allowed toward the routine eye exam and a $120 credit will apply to the purchase of eyewear. Claims must be filed by the Member.)**	

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

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.	

- Personal Health Assessment

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