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. – Base 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 | $5,000 | $6,000 per individual |
| Per Family (All family Members can contribute with no one Member contributing more than the individual deductible amount.) | $10,000 | |
| **Maximum Out-of-Pocket per Benefit Period** (includes deductible, coinsurance and all copays) | | |
| Per Member | $6,350 | $16,000 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 40% | Deductible, then 50% |
| Emergency room care | Deductible, then 40% | Deductible, then 40% |
| **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) | $60 first visit, then 40% | 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 40% | | Deductible, then 50% |
| Skilled Nursing Facility | Deductible, then 40% | | Deductible, then 50% |
| Long-term Acute Care | Deductible, then 40% | | Deductible, then 50% |
| **Outpatient/Ambulatory Care Facilities** | | | |
| All outpatient services (including maternity) | Deductible, then 40% | | Deductible, then 50% |
| Emergency room services | $125 per visit, then 40% | | 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<br>• 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. | | |

In-Network Covered Services are underwritten by BlueChoice HealthPlan of South Carolina, Inc. Out-of-Network Covered Services are underwritten by BlueCross BlueShield of South Carolina and administered by BlueChoice HealthPlan of South Carolina, Inc. BlueCross BlueShield of South Carolina and BlueChoice HealthPlan are independent licensees of the BlueCross and BlueShield Association.

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## Services other than Mental Health and Substance Use Disorders

| BENEFITS | In-Network<br>MEMBER PAYS | Out-of-Network<br>MEMBER PAYS<br>(Member must pay balance of Provider's Charge) |
|---|---|---|
| **Other Services** | | |
| Ambulance | Deductible, then 40% | Deductible, then 50% |
| Behavioral Therapy (ABA) for Autism Spectrum Disorder | Deductible, then 40% | Not Covered |
| Dental Services due to accidental injury | Deductible, then 40% | Not Covered |
| Durable Medical Equipment (DME) | Deductible, then 40% | Not Covered |
| Home Health | Deductible, then 40% | Deductible, then 50% |
| Hospice | Deductible, then 40% | Deductible, then 50% |
| Initial Prosthetic Appliances | Deductible, then 40% | Deductible, then 50% |
| Medical Supplies | Deductible, then 40% | Deductible, then 50% |
| Occupational Therapy | Deductible, then 40% | Not Covered |
| Outpatient Private Duty Nursing | Deductible, then 40% | Deductible, then 50% |
| Physical Therapy | Deductible, then 40% | Not Covered |
| Speech Therapy | Deductible, then 40% | 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<br>MEMBER PAYS | Out-of-Network<br>MEMBER PAYS<br>(Member must pay balance of Provider's Charge) |
|---|---|---|
| Inpatient Hospital Facility Services | Deductible, then 40% | Deductible, then 50% |
| Inpatient Physician Services | Deductible, then 40% | Deductible, then 50% |
| Outpatient Facility Institutional Services | Deductible, then 40% | Deductible, then 50% |
| Outpatient Facility Professional Services | Deductible, then 40% | 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 40% | 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