Non-Grandfathered

BlueChoice HealthPlan South Carolina

Schedule of Benefits

Business Advantage Silver 2500[SM]

Benefits are provided both In-network and Out-of-network. Using In-network providers will result in higher benefits.

All copays, deductible and coinsurance will apply toward the maximum out-of-pocket for in-network services. In order to be covered, all in-patient services must be authorized in advance. Benefits are subject to all terms, conditions, limitations, and exclusions outlined in the Contract.

BENEFITS	In-Network MEMBERS PAYS	Out-of-Network MEMBERS PAYS
Deductible per Benefit Period		
Individual	$2,500	N/A
Family	$5,000	
All family members can contribute with no one member contributing more than the Individual amount.		
Maximum Out-of-Pocket per Benefit Period (MOOP)		
Individual	$6,500	Unlimited
Family	$13,000	
Office Visit Services		
Primary Care Physician	$30 per visit	50%
Specialist Physician	$60 per visit	50%
Chiropractic services (5 visits)	Deductible, then 30%	50%
Doctors Care	$30 per visit	50%
Urgent Care	$50 per visit	50%
Professional Services (performed outside the office setting)		
Hospital services / Emergency Room care	Deductible, then 30%	50%
Maternity care (prenatal and postnatal)	$60 first visit	50%
Mental Health/Substance Abuse	$30 per visit	50%
Laboratory Outpatient	Deductible, then 30%	50%
X-rays and Diagnostic Imaging	Deductible, then 30%	50%
Imaging (CT/PET scans, MRIs)	Deductible, then 30%	50%
Mandated Preventive Care & Routine Care (includes mammogram and colonoscopy)	$0	50%
Facility Services / Inpatient Hospital		
Inpatient hospital (includes maternity and Mental Health/ Substance Abuse)	Deductible, then 30%	50%
Skilled Nursing Facility	Deductible, then 30%	50%

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South Carolina

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BENEFITS	In-Network MEMBERS PAYS		Out-of-Network MEMBERS PAYS
Facility Services / Outpatient Hospital			
Outpatient services (includes Ambulatory Surgical Center)	Deductible, then 30%		50%
Outpatient Surgery Physician/Surgical services	Deductible, then 30%		50%
Mental Health/Substance Abuse	Deductible, then 30%		50%
Emergency Room	Deductible, then 30%		Same as In-Network
Prescription Medication	Retail (up to a 31-day supply)	Mail Order (up to a 90-day supply)	Covered only at a Participating Provider.
Tier 1	$10	$20	
Tier 2	$10	$20	
Tier 3	$35	$70	
Tier 4	$60	$120	
Tier 5	$200	$400	
Tier 6	$200	$400	
* 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.		
Other Services			
Ambulance	Deductible, then 30%		50%
Dental services due to accidental injury	Deductible, then 30%		50%
Durable Medical Equipment (DME)	Deductible, then 30%		50%
Habilitative Services	Deductible, then 30%		50%
Home Health	Deductible, then 30%		50%
Hospice	Deductible, then 30%		50%
Initial Prosthetic Devices	Deductible, then 30%		50%
Rehabilitative Occupational, Physical & Speech Therapy	Deductible, then 30%		50%

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Plan Maximums	Plan Maximum Per Member
Durable Medical Equipment	Up to purchase price
Home Health	60 visits per Benefit Period
Hospice	6 months per episode
Rehabilitative Occupational Therapy, Physical Therapy, Speech Therapy and Habilitation	30 combined visits per Benefit Period
Prosthetic Devices	1 item per episode
Skilled Nursing Facility	60 days per Benefit Period
Benefit Period	Calendar Year

BENEFITS	In-Network MEMBERS PAYS	Out-of-Network MEMBERS PAYS
Pediatric Vision Care (VSP Network)		
One comprehensive vision exam per Calendar Year	$25 copayment	Not Covered
One pair of glasses (lenses and frames) per Calendar Year	$50 copayment	Not Covered
Covered lenses include single vision, lined bifocal, lined trifocal or lenticular lenses. Covered frames are from the Otis & Pieper Eyewear Collection.		
In lieu of eyeglasses, elective contact lens services and materials are covered once per Calendar Year for one of the following modalities: Standard (one pair annually), Monthly (six-month supply), Bi-weekly (three-month supply), Dailies (three-month supply).		
Necessary contact lenses are covered in full for members who have specific conditions for which contact lenses provide better visual correction.		

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Schedule of Benefits

*Business Advantage Silver 2500*SM

BENEFITS	In-Network MEMBERS PAYS	Out-of-Network MEMBERS PAYS
Adult 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	Not Covered
One standard contact lens fitting per Benefit Period	$45	Not Covered
One pair of eyewear from a designated selection every other Benefit Period	$0	Not Covered
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 towards the routine eye exam and $120 credit will apply to the purchase of eyewear. Claims must be filed by the Member.)		
Preventive Dental Care (any licensed dentist)		(No dental network)
One dental exam every six months initial/periodic	Balance over $27/$20	Balance over $27/$20
One dental cleaning every six months adult/child	Balance over $40/$31	Balance over $40/$31

BENEFITS	MEMBER PAYS
Employee Assistance Program (EAP Services)	
Individual & Family Counseling (visits 1-3)	$0
Life Management Services (3 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, seven days a week.	

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Business Advantage Silver 2500^{SM}

A Summary of Benefits and Coverage, also known as an SBC, is available to you online by using this link http://www.bluechoicesc.com/Silver2501. You may request a printed copy by calling the Customer Service phone number on the back of your ID card.

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