

Schedule of Benefits
BusinessADVANTAGE Gold 2503SM

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

Your Benefit Period is a Contract Year Benefit Period.

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	\$3,750	Unlimited
Family	\$7,500	
All family members can contribute with no one member contributing more than the Individual amount.		
Office Visit Services		
Primary Care Physician	\$25 per visit	50%
Specialist Physician	\$50 per visit	50%
Chiropractic services	Deductible, then 30%	50%
Doctors Care	\$25 per visit	Not Covered
Mental Health/Substance Abuse	\$25 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%
Laboratory Outpatient	Deductible, then 30%	50%
X-rays and Diagnostic Imaging	Deductible, then 30%	50%
Imaging (CT/PET scans, MRIs)	Deductible, then 30%	50%
Maternity Care		
Routine Maternity Physician Services (No additional copay for ongoing routine care)	Deductible, then 30%	50%
Mandated Preventive Care (includes mammogram and colonoscopy)	\$0	Not Covered
Facility Services / Inpatient Hospital		
Inpatient hospital (including maternity and Mental Health/ Substance Abuse)	Deductible, then 30%	50%
Skilled Nursing Facility	Deductible, then 30%	50%



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Facility Services / Outpatient Hospital		
Outpatient services (including maternity and Ambulatory Surgical Center)	Deductible, then 30%	50%
Freestanding Ambulatory Surgical Center (centers not affiliated with hospital)	\$200 per visit	Not Covered
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 (See Covered Drug List for Tier information)	Retail (up to a 31-day supply)	Mail Order (up to a 90-day supply)
Tier 1	\$10	\$20
Tier 2	\$10	\$20
Tier 3	\$35	\$70
Tier 4	\$70	\$140
Tier 5	\$250	\$500
Tier 6	\$250	\$500
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%
Pediatric Vision Care (PEN) Providers Only (Refer to Provider Directory) (Physicians EyeCare Network (PEN) is an independent company that provides adult vision services on behalf of BlueChoice HealthPlan, Inc. of South Carolina.)		
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



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Adult Routine Vision Care - Physicians EyeCare Network (PEN) Providers Only (Refer to Provider Directory) (Physicians EyeCare Network (PEN) is an independent company that provides adult vision services on behalf of BlueChoice HealthPlan, Inc. of South Carolina.)	(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
(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.)		

BENEFITS	MEMBER PAYS
Employee Assistance Program (EAP Services) Individual & Family Counseling (visits 1-3) Life Management Services (3 visits)	 \$0 \$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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Preventive Dental Services

CarolinaADVANTAGESM

Preventive Dental is automatically included in all BlueChoice HealthPlan CarolinaADVANTAGESM plans. It covers an allowed amount per benefit period for exams and cleanings at any licensed dentist.

Services	Allowance Every Six Months
One exam	
Initial / Periodic	\$27 / \$20
One cleaning	
Adult / Child	\$40 / \$31

Members can send a completed member claim form and the paid receipt to BlueChoice for reimbursement of the allowed amount.

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BusinessADVANTAGESM

Preventive Dental is automatically included in all BlueChoice HealthPlan BusinessADVANTAGESM plans. It covers an allowed amount per benefit period for exams and cleanings at any licensed dentist.

Services	Allowance Every Six Months
One exam	\$50 allowance for initial/\$50 allowance for periodic <i>(Periodic would be for a regular checkup. The plan pays the same amount for adults and children.)</i>
One cleaning	\$50 allowance

Members are responsible for paying any additional balance above what we cover. For example, if the dentist charges \$130 for an initial cleaning and exam, the member will pay the dentist \$130 at the time of service. We will reimburse the member \$100 once we receive the reimbursement form.

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