BlueChoice HealthPlan South Carolina

Non-Grandfathered

Schedule of Benefits

BusinessAdvantage Gold 1502SM

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

Your Benefit Period is a Calendar 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	$1,500	N/A
Family	$3,000	
All family members can contribute with no one member contributing more than the Individual amount.		
Maximum Out-of-Pocket per Benefit Period (MOOP)		
Individual	$5,000	Unlimited
Family	$10,000	
All family members can contribute with no one member contributing more than the Individual amount.		
Office Visit Services		
Primary Care Physician	$15 per visit	50%
Specialist Physician	$45 per visit	50%
Chiropractic services - limited to 5 visits	Deductible, then 30%	50%
Doctors Care	$15 per visit	50%
Mental Health/Substance Abuse	$15 per visit	50%
Urgent Care	$50 per visit	50%
Professional Services (performed outside the office setting)		
Hospital services	Deductible, then 30%	50%
Emergency Room care (In order for Emergency Room care to be covered, care must be for an Emergency Medical Condition)	Deductible, then 30%	Deductible, then 30% (Plus any amount above the allowable amount up to the billed amount)
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 Physicians Services (No additional copay for ongoing routine care)	$45 first visit	50%
Mandated Preventive Care (includes mammogram and colonoscopy)	$0	Not Covered

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Facility Services / Inpatient Hospital			
Inpatient hospital (including maternity and Mental Health/Substance Abuse)	Deductible, then 30%		50%
Skilled Nursing Facility	Deductible, then 30%		50%
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		50%
Outpatient Surgery Physician/Surgical services	Deductible, then 30%		50%
Mental Health/Substance Abuse	Deductible, then 30%		50%
Emergency Room (In order for Emergency Room care to be covered, care must be for an Emergency Medical Condition.)	Deductible, then 30%		Deductible, then 30% (Plus any amount above the allowable amount up to the billed amount)
Prescription Medication (see Covered Drug List for Tier information)	Retail (up to a 31-day supply)	Mail Order (up to a 90-day supply)	Covered only at a Participating Provider.
Tier 1	$15	$30	
Tier 2	$15	$30	
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%

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BENEFITS	In-Network MEMBERS PAYS	Out-of-Network MEMBERS PAYS
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
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)	$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 is available 24 hours a day, seven days a week.	

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BlueChoice HealthPlan
South Carolina

Preventive Dental Services

CarolinaADVANTAGE℠

Preventive Dental is automatically included in all BlueChoice HealthPlan CarolinaADVANTAGE℠ 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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BusinessADVANTAGE℠

Preventive Dental is automatically included in all BlueChoice HealthPlan BusinessADVANTAGE℠ 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 *(Periodic would be for a regular checkup. The plan pays the same amount for adults and children.)*
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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