

**Schedule of Benefits**  
***Business Advantage Silver 2850<sup>SM</sup>***

**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.		
<b>BENEFITS</b>	<b>In-Network MEMBERS PAYS</b>	<b>Out-of-Network MEMBERS PAYS</b>
<b>Deductible per Benefit Period</b>		
Individual	\$2,850	N/A
Family	\$5,700	
All family members can contribute with no one member contributing more than the Individual amount.		
<b>Maximum Out-of-Pocket per Benefit Period (MOOP)</b>		
Individual	\$8,000	Unlimited
Family	\$16,000	
All family members can contribute with no one member contributing more than the Individual amount.		
<b>Office Visit Services</b>		
Primary Care Physician	\$35 per visit	50%
Specialist Physician	\$65 per visit	50%
Chiropractic services - limited to 5 visits	Deductible, then 45%	50%
Doctors Care	\$35 per visit	50%
Mental Health/Substance Abuse	\$35 per visit	50%
<b>Urgent Care</b>	\$50 per visit	50%
<b>Professional Services</b> (performed outside the office setting)		
Hospital services	Deductible, then 45%	50%
Emergency Room care (In order for Emergency Room care to be covered, care must be for an Emergency Medical Condition)	Deductible, then 45%	Deductible, then 45% (Plus any amount above the allowable amount up to the billed amount)
Laboratory Outpatient	Deductible, then 45%	50%
X-rays and Diagnostic Imaging	\$250, then Deductible, then 45%	50%
Imaging (CT/PET scans, MRIs)	Deductible, then 45%	50%
<b>Maternity Care</b>		
Routine Maternity Physicians Services (No additional copay for ongoing routine care)	\$65 first visit	50%
<b>Mandated Preventive Care</b> (includes mammogram and colonoscopy)	\$0	Not Covered

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BENEFITS	In-Network MEMBERS PAYS	Out-of-Network MEMBERS PAYS
<b>Facility Services / Inpatient Hospital</b>		
Inpatient hospital (including maternity and Mental Health/Substance Abuse)	\$250 per stay, then Deductible, then 45%	50%
Skilled Nursing Facility	Deductible, then 45%	50%
<b>Facility Services / Outpatient Hospital</b>		
Outpatient services (including maternity and Ambulatory Surgical Center)	Deductible, then 45%	50%
Freestanding Ambulatory Surgical Center (centers not affiliated with Hospital)	\$200 per visit	50%
Outpatient Surgery Physician/Surgical services	Deductible, then 45%	50%
Mental Health/Substance Abuse	Deductible, then 45%	50%
Emergency Room (In order for Emergency Room care to be covered, care must be for an Emergency Medical Condition.)	\$250, then Deductible, then 45%	\$250, then Deductible, then 45% (Plus any amount above the allowable amount up to the billed amount)
<b>Prescription Medication</b> (see Covered Drug List for Tier information)	Retail (up to a 31-day supply)	Mail Order (up to a 90-day supply)
Tier 1	\$25	\$50
Tier 2	\$25	\$50
Tier 3	\$45	\$90
Tier 4	\$75	\$150
Tier 5	\$300	\$600
Tier 6	\$300	\$600
		Covered only at a Participating Provider.
<b>Other Services</b>		
Ambulance	Deductible, then 45%	50%
Dental services due to accidental injury	\$250, then Deductible, then 45%	50%
Durable Medical Equipment (DME)	Deductible, then 45%	50%
Habilitative Services	\$250, then Deductible, then 45%	50%
Home Health	\$250, then Deductible, then 45%	50%
Hospice	\$250, then Deductible, then 45%	50%
Initial Prosthetic Devices	\$250, then Deductible, then 45%	50%
Rehabilitative Occupational, Physical & Speech Therapy	Deductible, then 45%	50%



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BENEFITS	In-Network MEMBERS PAYS	Out-of-Network MEMBERS PAYS
<p><b>Pediatric Vision Care (PEN) Providers Only</b> <b>(Refer to Provider Directory)</b> (Physicians EyeCare Network (PEN) is an independent company that provides adult vision services on behalf of BlueChoice HealthPlan, Inc. of South Carolina.)</p> <p>One comprehensive vision exam per Calendar Year</p> <p>One pair of glasses (lenses and frames) per Calendar Year</p>	<p>\$25 copayment</p> <p>\$50 copayment</p>	<p>Not Covered</p> <p>Not Covered</p>
<p><b>Adult Routine Vision Care - Physicians EyeCare Network (PEN) Providers Only (Refer to Provider Directory)</b> (Physicians EyeCare Network (PEN) is an independent company that provides adult vision services on behalf of BlueChoice HealthPlan, Inc. of South Carolina.)</p> <p>One routine eye exam or one exam for contact lenses per Benefit Period</p> <p>One standard contact lens fitting per Benefit Period</p> <p>One pair of eyewear from a designated selection every other Benefit Period</p> <p><b>(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.)</b></p>	<p>(Authorization not required)</p> <p>\$0</p> <p>\$45</p> <p>\$0</p>	<p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p>

BENEFITS	MEMBER PAYS
<p><b>Employee Assistance Program (EAP Services)</b></p> <p>Individual &amp; Family Counseling (visits 1-3)</p> <p>Life Management Services (3 visits)</p> <p><b>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.</b></p>	<p>\$0</p> <p>\$0</p>

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## Preventive Dental Services

### **CarolinaADVANTAGE<sup>SM</sup>**

Preventive Dental is automatically included in all BlueChoice HealthPlan CarolinaADVANTAGE<sup>SM</sup> plans. It covers an allowed amount per benefit period for exams and cleanings at any licensed dentist.

Services	Allowance Every Six Months
<b>One exam</b> <b>Initial / Periodic</b>	\$27 / \$20
<b>One cleaning</b> <b>Adult / Child</b>	\$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<sup>SM</sup>**

Preventive Dental is automatically included in all BlueChoice HealthPlan BusinessADVANTAGE<sup>SM</sup> plans. It covers an allowed amount per benefit period for exams and cleanings at any licensed dentist.

Services	Allowance Every Six Months
<b>One exam</b>	\$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>
<b>One cleaning</b>	\$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.