BlueChoice HealthPlan South Carolina

Non-Grandfathered

Schedule of Benefits
BusinessAdvantage Silver 7100SM

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	$7,100	N/A
Family	$14,200	
All family members can contribute with no one member contributing more than the Individual amount.		
Maximum Out-of-Pocket per Benefit Period (MOOP)		
Individual	$8,150	Unlimited
Family	$16,300	
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	$50 per visit	50%
Chiropractic services - limited to 5 visits	Deductible, then 20%	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 20%	50%
Emergency Room care (In order for Emergency Room care to be covered, care must be for an Emergency Medical Condition)	Deductible, then 20%	Deductible, then 20% (Plus any amount above the allowable amount up to the billed amount)
Laboratory Outpatient	$500, then Deductible, then 20%	50%
X-rays and Diagnostic Imaging	$500, then Deductible, then 20%	50%
Imaging (CT/PET scans, MRIs)	Deductible, then 20%	50%
Maternity Care Routine Maternity Physicians Services (No additional copay for ongoing routine care)	$50 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)	$500 per stay, then Deductible, then 20%		50%
Skilled Nursing Facility	$500 per stay, then Deductible, then 20%		50%
Facility Services / Outpatient Hospital			
Outpatient services (including maternity and Ambulatory Surgical Center)	Deductible, then 20%		50%
Freestanding Ambulatory Surgical Center (centers not affiliated with Hospital)	$200 per visit		50%
Outpatient Surgery Physician/Surgical services	Deductible, then 20%		50%
Mental Health/Substance Abuse	Deductible, then 20%		50%
Emergency Room (In order for Emergency Room care to be covered, care must be for an Emergency Medical Condition.)	$500, then Deductible, then 20%		$500, then Deductible, then 20% (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	Deductible, then 20%	Deductible, then 20%	
Tier 5	Deductible, then 20%	Deductible, then 20%	
Tier 6	Deductible, then 20%	Deductible, then 20%	
Other Services			
Ambulance	Deductible, then 20%		50%
Dental services due to accidental injury	$500, then Deductible, then 20%		50%
Durable Medical Equipment (DME)	Deductible, then 20%		50%
Habilitative Services	$500, then Deductible, then 20%		50%
Home Health	$500, then Deductible, then 20%		50%
Hospice	$500, then Deductible, then 20%		50%
Initial Prosthetic Devices	$500, then Deductible, then 20%		50%
Rehabilitative Occupational, Physical & Speech Therapy	Deductible, then 20%		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.	