BlueChoice HealthPlan
South Carolina

# Schedule of Benefits
## *Blue Option Bronze 5550$^{SM}$*

| | | |
|---|---|---|
| Member's Name: | Effective Date: | Benefit Period: 1/1-12/31 |
| Member's ID Number: | Total Premium: | Type of Plan: Single/Family |
| Covered Dependents: | | |

**Benefits are provided in-network only. No benefits are provided for services received out-of-network unless the service is due to an emergency or the service is not available at a Network Provider.**

**Your Benefit Period is a Calendar Year Benefit Period.**

| BENEFITS | MEMBERS PAYS |
|---|---|
| **Deductible per Benefit Period** | |
| Individual | $5,550 |
| Family | $11,100 |
| All family members can contribute with no one member contributing more than the Individual amount. | |
| **Maximum Out-of-Pocket per Benefit Period (MOOP)** | |
| Individual | $8,550 |
| Family | $17,100 |
| All family members can contribute with no one member contributing more than the Individual amount. | |
| **Office Visit Services** | |
| Primary Care Physician | $60 per visit |
| Specialist Physician | Deductible, then 35% |
| Doctors Care | $60 per visit |
| Mental Health/Substance Abuse | $60 per visit |
| **Urgent Care** | $75 per visit |
| **Professional Services** (performed outside the office setting) | |
| Hospital services | Deductible, then 35% |
| Emergency Room care<br>(in order for Emergency Room care to be covered, care must be for an Emergency Medical Condition.) | Deductible, then 35% (If Emergency Room Care is received for an Emergency Medical Condition outside of the Network, the Member will be responsible for any amounts above the allowable amount up to the billed amount.) |
| Laboratory Outpatient | $500, then Deductible, then 35% |
| X-rays and Diagnostic Imaging | $500, then Deductible, then 35% |
| Imaging (CT/PET scans, MRIs) | Deductible, then 35% |
| **Maternity Care**<br>Routine Maternity Physician Services<br>(No additional copay for ongoing routine care) | Deductible, then 35% |
| **Mandated Preventive Care**<br>(includes mammogram and colonoscopy) | $0 |

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|---|---|---|
| **Facility Services / Inpatient Hospital** | | |
| Inpatient hospital (includes maternity) | $500 per stay, then Deductible, then 35% | |
| Mental Health/Substance Abuse | Deductible, then 35% | |
| Skilled Nursing Facility | $500 per stay, hen Deductible, then 35% | |
| **Facility Services / Outpatient Hospital** | | |
| Outpatient services (includes Ambulatory Surgical Center and maternity) | Deductible, then 35% | |
| Freestanding Ambulatory Surgical Center (centers not affiliated with Hospital) | $200 per visit | |
| Outpatient Surgery Physician/Surgical services | Deductible, then 35% | |
| Mental Health/Substance Abuse | Deductible, then 35% | |
| Emergency Room (in order for Emergency Room care to be covered, care must be for an Emergency Medical Condition) | $500, then Deductible, then 35%<br>(If Emergency Room Care is received for an Emergency Medical Condition outside of the Network, the Member will be responsible for any amounts above the allowable amount up to the billed amount. ) | |
| **Prescription Medication**<br>(see Covered Drug List for Tier Information) | Retail (up to a 31-day supply) | Mail Order (up to a 90-day supply) |
| Tier 1 | Deductible, then 35% | Deductible, then 35% |
| Tier 2 | Deductible, then 35% | Deductible, then 35% |
| Tier 3 | Deductible, then 35% | Deductible, then 35% |
| Tier 4 | Deductible, then 35% | Deductible, then 35% |
| Tier 5 | Deductible, then 35% | Deductible, then 35% |
| Tier 6 | Deductible, then 35% | Deductible, then 35% |
| **Other Services** | | |
| Ambulance | Deductible, then 35% | |
| Dental services due to accidental injury | Deductible, then 35% | |
| Durable Medical Equipment (DME) | Deductible, then 35% | |
| Habilitative Services | Deductible, then 35% | |
| Home Health | Deductible, then 35% | |
| Hospice | Deductible, then 35% | |
| Initial Prosthetic Devices | Deductible, then 35% | |
| Rehabilitative Occupational, Physical & Speech Therapy | Deductible, then 35% | |

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| BENEFITS | MEMBERS PAYS |
|---|---|
| **Pediatric Vision Care –Physicians Eye Plan (PEP) Providers Only (Refer to Provider Directory)**<br><br>Pediatric Vision Care is provided under an agreement with Physicians EyeCare Network (PEN) and Blue Choice. PEN is an independent company that provides vision services on behalf of BlueChoice HealthPlan, Inc. of South Carolina. | |
| One comprehensive vision exam per Benefit Period | $15 Copayment |
| One standard contact lens fitting per Benefit Period | $49 Copayment |
| **$150 will be allowed toward the purchase of frames, lenses, lens options or contacts**<br>**(Consult your PEP Provider for more information on discounts for which you may be eligible)** | $25 Copayment |

The following services are added services to your coverage. These services are do not count toward your Deductible or Maximum Out-of-Pocket.

| BENEFITS | MEMBERS PAYS |
|---|---|
| **Adult Routine Vision Care – Physicians Eye Plan (PEP) Providers Only (Refer to Provider Directory)**<br><br>Adult Routine Vision Care is provided under an agreement with Physicians EyeCare Network (PEN) and Blue Choice. PEN is an independent company that provides adult vision services on behalf of BlueChoice HealthPlan, Inc. of South Carolina. | (Authorization not required) |
| One comprehensive vison exam per Benefit Period | $0 |
| One standard contact lens fitting per Benefit Period | $49 |
| **$150 will be allowed toward the purchase of frames, lenses, lens options or contacts**<br>**(Consult your PEP Provider for more information on discounts for which you may be eligible)** | |
| **Preventive Dental Care (any licensed dentist)** | |
| One dental exam every six months, a maximum of two per Benefit Period | Balance over $50 |
| One dental cleaning every six months, a maximum of two per Benefit Period | Balance over $50 |

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| BENEFITS | MEMBERS PAYS |
|---|---|
| **Life Management Services (3 visits)**<br><br>Benefits are provided under an agreement between First Sun EAP and BlueChoice. 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. | $0 |