

**Schedule of Benefits**  
**Blue Option Silver 5550<sup>SM</sup>**

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
<b>Deductible per Benefit Period</b>	
Individual	\$5,550
Family	\$11,100
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	\$7,350
Family	\$14,700
All family members can contribute with no one member contributing more than the Individual amount.	
<b>Office Visit Services</b>	
Primary Care Physician	\$45 per visit
Specialist Physician	\$100 per visit
Doctors Care	\$45 per visit
Mental Health/Substance Abuse	\$45 per visit
<b>Urgent Care</b>	\$50 per visit
<b>Professional Services</b> (performed outside the office setting)	
Hospital services	Deductible, then 20%
Emergency Room care (in order for Emergency Room care to be covered, care must be for an Emergency Medical Condition.)	Deductible, then 20% (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 20%
X-rays and Diagnostic Imaging	\$500, then Deductible, then 20%
Imaging (CT/PET scans, MRIs)	Deductible, then 20%
<b>Maternity Care</b>	
Routine Maternity Physician Services (No additional copay for ongoing routine care)	\$100 first visit
<b>Mandated Preventive Care</b> (includes mammogram and colonoscopy)	\$0

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<p><b>Facility Services / Inpatient Hospital</b></p> <p>Inpatient hospital (includes maternity)</p> <p>Mental Health/Substance Abuse</p> <p>Skilled Nursing Facility</p>	<p>\$500 per stay, then Deductible, then 20%</p> <p>Deductible, then 20%</p> <p>\$500 per stay, then Deductible, then 20%</p>														
<p><b>Facility Services / Outpatient Hospital</b></p> <p>Outpatient services (includes Ambulatory Surgical Center and maternity)</p> <p>Freestanding Ambulatory Surgical Center (centers not affiliated with Hospital)</p> <p>Outpatient Surgery Physician/Surgical services</p> <p>Mental Health/Substance Abuse</p> <p>Emergency Room (in order for Emergency Room care to be covered, care must be for an Emergency Medical Condition)</p>	<p>Deductible, then 20%</p> <p>\$200 per visit</p> <p>Deductible, then 20%</p> <p>Deductible, then 20%</p> <p>\$500, then Deductible, then 20% (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. )</p>														
<p><b>Prescription Medication</b> (see Covered Drug List for Tier Information)</p> <p>Tier 1</p> <p>Tier 2</p> <p>Tier 3</p> <p>Tier 4</p> <p>Tier 5</p> <p>Tier 6</p>	<table> <tr> <td>Retail (up to a 31-day supply)</td> <td>Mail Order (up to a 90-day supply)</td> </tr> <tr> <td>\$15</td> <td>\$30</td> </tr> <tr> <td>\$15</td> <td>\$30</td> </tr> <tr> <td>\$35</td> <td>\$70</td> </tr> <tr> <td>Deductible, then 20%</td> <td>Deductible, then 20%</td> </tr> <tr> <td>Deductible, then 20%</td> <td>Deductible, then 20%</td> </tr> <tr> <td>Deductible, then 20%</td> <td>Deductible, then 20%</td> </tr> </table>	Retail (up to a 31-day supply)	Mail Order (up to a 90-day supply)	\$15	\$30	\$15	\$30	\$35	\$70	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%
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<p><b>Other Services</b></p> <p>Ambulance</p> <p>Dental services due to accidental injury</p> <p>Durable Medical Equipment (DME)</p> <p>Habilitative Services</p> <p>Home Health</p> <p>Hospice</p> <p>Initial Prosthetic Devices</p> <p>Rehabilitative Occupational, Physical &amp; Speech Therapy</p>	<p>Deductible, then 20%</p> <p>Deductible, then 20%</p> <p>Deductible, then 20%</p> <p>Deductible, then 20%</p> <p>Deductible, then 20%</p> <p>Deductible, then 20%</p> <p>Deductible, then 20%</p> <p>Deductible, then 20%</p>														

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<b>BENEFITS</b>	<b>MEMBERS PAYS</b>
<p><b>Pediatric Vision Care –Physicians Eye Plan (PEP) Providers Only (Refer to Provider Directory)</b></p> <p>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.</p> <p>One comprehensive vision exam per Benefit Period</p> <p>One standard contact lens fitting per Benefit Period</p> <p><b>\$150 will be allowed toward the purchase of frames, lenses, lens options or contacts</b> <b>(Consult your PEP Provider for more information on discounts for which you may be eligible)</b></p>	<p>\$15 Copayment</p> <p>\$49 Copayment</p> <p>\$25 Copayment</p>

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

<b>BENEFITS</b>	<b>MEMBERS PAYS</b>
<p><b>Adult Routine Vision Care – Physicians Eye Plan (PEP) Providers Only (Refer to Provider Directory)</b></p> <p>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.</p> <p>One comprehensive vision exam per Benefit Period</p> <p>One standard contact lens fitting per Benefit Period</p> <p><b>\$150 will be allowed toward the purchase of frames, lenses, lens options or contacts</b> <b>(Consult your PEP Provider for more information on discounts for which you may be eligible)</b></p>	<p>(Authorization not required)</p> <p>\$0</p> <p>\$49</p>
<p><b>Preventive Dental Care (any licensed dentist)</b></p> <p>One dental exam every six months, a maximum of two per Benefit Period</p> <p>One dental cleaning every six months, a maximum of two per Benefit Period</p>	<p>Balance over \$50</p> <p>Balance over \$50</p>



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<b>BENEFITS</b>	<b>MEMBERS PAYS</b>
<p><b>Life Management Services (3 visits)</b></p> <p>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.</p>	<p>\$0</p>