BlueChoice HealthPlan
South Carolina

Schedule of Benefits
Choice Complete Bronze 4000SM

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. 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 Certificate of Coverage/Contract.

BENEFITS	In-Network MEMBERS PAYS	Out-of-Network MEMBERS PAYS
Deductible per Benefit Period		
Individual	$4,000[1]	N/A
Family	$8,000[1]	
All family members can contribute with no one member contributing more than the Individual amount.		
Maximum Out-of-Pocket per Benefit Period (MOOP)		
Individual	$9,000[1]	Unlimited
Family	$18,000[1]	
All family members can contribute with no one member contributing more than the Individual amount.		
Office Visit Services		
Primary Care Physician (including Behavioral Health)	Deductible, then 50%	50%
Blue CareOnDemandSM Powered by MDLive (Blue CareOnDemand is offered through MDLive, an independent company that provides telehealth hosting and software services on behalf of BlueChoice)	$0 per visit	50%
Specialist Physician	Deductible, then 50%	50%
Chiropractic services - limited to 5 visits	Deductible, then 50%	Not Covered
Urgent Care	Deductible, then 50% (includes In-Network and Out-of-Network Emergency services for an Emergency Medical Condition)	50%

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South Carolina

Schedule of Benefits
Choice Complete Bronze 4000SM

BENEFITS	In-Network MEMBERS PAYS		Out-of-Network MEMBERS PAYS
Professional Services (performed outside the office setting)			
Hospital services	Deductible, then 50%[2]		50%
Outpatient surgery	Deductible, then 50%		50%
Laboratory Outpatient	Deductible, then 50%		50%
X-rays and Diagnostic Imaging	Deductible, then 50%		50%
Imaging (CT/PET scans, MRIs)	Deductible, then 50%		50%
Maternity Care (other than Mandated Preventive Care) Routine Maternity Physicians Services	Deductible, then 50%		50%
Mandated Preventive Care (includes mammogram and colonoscopy)	$0		Not Covered
Hospital/Facility Services Inpatient hospital (including maternity and Behavioral Health)	Deductible, then 50%[2]		50%
Skilled Nursing Facility and Residential Treatment Facility	Deductible, then 50%[2]		50%
Outpatient Hospital/Facility Services			
Outpatient services (including maternity, Behavioral Health and Ambulatory Surgical Center)	Deductible, then 50%[2]		50%
Outpatient Surgery services	$300, then Deductible, then 50%[2]		50%
Freestanding Ambulatory Surgical Center (centers not affiliated with Hospital)	$200 per visit[3]		50%
Emergency Room (includes professional services) – In order for Emergency Room care to be covered, care must be for an Emergency Medical Condition.	$300, then Deductible, then 50%		$300, then Deductible, then 50% (Member is not required to pay balance of Provider's Charge)
Prescription Medication (see Prescription 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	$25	$50	
Tier 2	$45	$90	
Tier 3	$125	$250	
Tier 4	$350	$700	
Tier 5	$350	$700	
Tier 6	$350	$700	

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South Carolina

Schedule of Benefits
Choice Complete Bronze 4000SM

BENEFITS	In-Network MEMBERS PAYS	Out-of-Network MEMBERS PAYS
Other Services		
Ambulance	Deductible, then 50%	50%
Dental services due to accidental injury	Deductible, then 50%	50%
Durable Medical Equipment (DME)	Deductible, then 50%	50%
Habilitative Services	Deductible, then 50%	50%
Home Health	Deductible, then 50%	50%
Hospice	Deductible, then 50%	50%
Initial Prosthetic Devices	Deductible, then 50%	50%
Rehabilitative, Occupational, Physical & Speech Therapy	Deductible, then 50%	50%
Pediatric Vision Care EyeMed Providers Only (Refer to Provider Directory) (EyeMed is an independent company that provides pediatric vision services on behalf of BlueChoice.)		
Exam with Dilation as necessary	$25 copayment	Balance over $30
Retinal Imaging	Up to $39	N/A
Exam – Standard Contact Lens Fit and Follow-up	Up to $40	N/A
Exam – Premium Contact Lens Fit and Follow-up	10% off Retail Price	N/A
Frames: Any available frame at provider location	$50 copayment, 100% coverage for Provider designated frames	Balance over $60
Standard Plastic Lenses		
Single vision	$0 copayment	Balance over $25
Bifocal	$0 copayment	Balance over $45
Trifocal	$0 copayment	Balance over $55
Lenticular	$0 copayment	Balance over $55
Standard Progressive Lens	$0 copayment	Balance over $55
Lens Options:		
UV Treatment	$15	Not Applicable
Tint (Solid and Gradient)	$15	Not Applicable
Standard Plastic Scratch Coating	$15	Not Applicable
Standard Polycarbonate – Kids under 19	$0 copayment	Balance over $5
Standard Anti-Reflective Coating	$45	Not Applicable
Polarized	20% off Retail Price	Not Applicable
Oversized	20% off Retail Price	Not Applicable
Other Add-Ons	20% off Retail Price	Not Applicable

BlueChoice® HealthPlan
South Carolina

Schedule of Benefits
Choice Complete Bronze 4000SM

BENEFITS	In-Network MEMBERS PAYS	Out-of-Network MEMBERS PAYS
Pediatric Vision Care EyeMed Providers Only Continued **(Refer to Provider Directory)** (EyeMed is an independent company that provides pediatric vision services on behalf of BlueChoice.)		
Contact Lens (Includes materials only) Conventional	$50 copayment, 100% coverage for Provider designated contact lenses	Balance over $112
Disposable	$50 copayment, 100% coverage for Provider designated contact lenses	Balance over $112
Medically Necessary	0%	Balance over $210
Additional Pairs Benefit	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional lenses once the contact lens allowance has been used.	Not Applicable
Laser Vision Correction: Lasik or PRK from U.S. Laser Network	15% of Retail Price or 5% off promotional price	Not Applicable
Exams, frames lenses and contact lenses are limited to one per Member per Benefit Period.		

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South Carolina

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

BENEFITS	In-Network MEMBERS PAYS	Out-of-Network MEMBERS PAYS
Adult Routine Vision Care EyeMed Providers Only **(Refer to Provider Directory)** (EyeMed is an independent company that provides adult vision services on behalf of BlueChoice.)		
Exam with Dilation as necessary	$0 copayment	Balance over $30
Retinal Imaging	Up to $39	N/A
Frames, Lens & Options Package: Any frame, lens and lens option available at Provider location	$120 allowance for frame, lens and lens options, 20% off balance over $120	Balance over $60
Contact Lens Conventional	$0 copayment, $120 allowance, 15% off balance over $120	Balance over $96
Disposable	$0 copayment, $120 allowance, plus balance over $120	Balance over $96
Medically Necessary	$0 copayment	Balance over $210
Additional Pairs Benefit	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional lenses once the contact lens allowance has been used.	Not Applicable
Laser Vision Correction: Lasik or PRK from U.S. Laser Network	15% of Retail Price or 5% off promotional price	Not Applicable
Exams are limited to one per Member per Benefit Period. Frames, lenses and contact lenses are limited to one per Member every two years.		
Preventive Dental Care (any licensed dentist)		(No dental network)
One dental exam every six months, a maximum of two per Benefit Period	Balance over $50	Balance over $50
One dental cleaning every six months, a maximum of two per Benefit Period	Balance over $50	Balance over $50

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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 from BlueChoice. First Sun EAP is responsible for all services it provides. 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.	

[1] Includes Out-of-Network air ambulance services, Emergency Services, and subject to limited provider advance notice and consent requirements, other (non-Emergency) services furnished at certain In-Network facilities.

[2] Includes Out-of-Network Emergency services, and subject to limited provider advance notice and consent requirements, post-stabilization services resulting from an Emergency, and services provided by an Out-of-Network Provider at certain In-Network facilities.

[3] Includes services provided by an Out-of-Network Provider at an In-Network Freestanding Ambulatory Surgical Center.