Schedule of Benefits
Advantage Plus
Spartanburg County – 2011 Enhanced Plan

In order to receive In-Network benefits, all services must be provided by a BlueChoice HealthPlan Participating Provider. This applies to each individual service unless otherwise noted. All admissions must be authorized by BlueChoice HealthPlan in order to be covered. Benefits are subject to all terms, conditions, limitations, and exclusions outlined in the Contract.

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Deductible per Benefit Period		
Per Member	$1,000	$2,000 per individual
Per Family (All family Members can contribute with no one Member contributing more than the individual deductible amount.)	$3,000	
Maximum Coinsurance per Benefit Period		
Per Member	$2,000	$4,000
Per Family	$4,000	$8,000
Primary Care		
Office services (includes routine/preventive care)	$35 per visit	Deductible, then 40%
Hospital services	$0	Deductible, then 40%
Specialty Care		
Office services	$50 per visit	Deductible, then 40%
Hospital services (includes inpatient, outpatient & ambulatory care services)	Deductible, then 20%	Deductible, then 40%
Emergency room care	Deductible, then 20%	Deductible, then 20%
Other Routine Care		
GYN Exam	$35 per visit	Deductible, then 40%
Routine Screening Mammogram	$0	Deductible, then 40%
Routine Screening Colonoscopy	$0	Deductible, then 40%
Maternity Care		
Routine Maternity Physician Services	Deductible, then 20%	Deductible, then 40%
Inpatient Hospital/Facility Services (Authorization required)		
Admission (including maternity)	$500 per admission, then 20%	Deductible, then 40%
Skilled Nursing and Long-term Acute Care Facility - 120 days per Benefit Period	Deductible, then 20%	Deductible, then 40%

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BENEFITS	In-Network MEMBER PAYS		Out-of-Network MEMBER PAYS
Outpatient/Ambulatory Care Facilities			
All services (including maternity)	Deductible, then 20%		Deductible, then 40%
Emergency room services	$200 per visit, then 20%		Same as In-Network
Urgent care	$35 per visit		Deductible, then 40%
Prescription Medicine	Retail (up to a 31-day supply)	Mail Order (up to a 90-day supply)	Covered only at a Participating Pharmacy
Value Generic	$8	$20.00	
Generic drug and designated over-the-counter drug	$15	$37.50	
Preferred brand-name drug	$35	$87.50	
Non-preferred brand-name drug	$55	$137.50	
No max per Benefit Period	You may have to pay more if you select a brand-name drug instead of a generic drug.		
Specialty Pharmaceuticals			Not Covered
Injectable medication	$125 per administration $80 per administration for select drugs		
Oral medication	$125 for up to a 31-day supply		
Mental Health & Substance Use Disorders (All services must be authorized in advance by Companion Benefit Alternatives at 1-800-868-1032) See **Other Services** for Behavioral Therapy (ABA) benefit	Same as for any other condition		Same as for any other condition

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BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Other Services		
Occupational Therapy – 20 visits per Benefit Period	Deductible, then 20%	Not Covered
Physical Therapy – 20 visits per Benefit Period	Deductible, then 20%	Not Covered
Speech Therapy – 20 visits per Benefit Period	Deductible, then 20%	Not Covered
Behavioral Therapy (ABA) for Autism Spectrum Disorder - $50,000 maximum per benefit period	Deductible, then 20%	Not Covered
Ambulance	Deductible, then 20%	Deductible, then 40%
Home Health	Deductible, then 20%	Deductible, then 40%
Private Duty Nursing - up to 60 days per Benefit Period	Deductible, then 20%	Deductible, then 40%
Hospice	Deductible, then 20%	Deductible, then 40%
Initial Prosthetic Appliances	Deductible, then 20%	Deductible, then 40%
Medical Supplies	Deductible, then 20%	Deductible, then 40%
Dental Services due to accidental injury - $500 max per Benefit Period	Deductible, then 20%	Not Covered
Durable Medical Equipment (DME) - $5,000 maximum per Benefit Period	Deductible, then 20%	Not Covered
Chiropractic Services - $1,000 maximum per Benefit Period	$50 per visit	Not Covered
Transplants		
Covered transplants	Maximum benefit per transplant	
Kidney (single)	$60,000	
Pancreas/Kidney	$80,000	
Heart	$120,000	
Lung (single)	$130,000	
Lung (double)	$250,000	
Liver	$225,000	
Pancreas	$80,000	
Heart/Lung	$175,000	
Bone Marrow/Stem Cell	$250,000	
Cornea	$25,000	
Lifetime Transplant Maximum Benefit	$250,000	
Lifetime Benefit Maximum	$2,000,000	
Benefit Period	Contract Year	

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BENEFITS	MEMBER PAYS
Routine Vision Care - Physicians EyeCare Network (PEN) Providers Only (Refer to Provider Directory)	**(Authorization not required)**
One routine eye exam or one exam for contact lenses per Benefit Period	$0
One standard contact lens fitting per Benefit Period	$45
One pair of eyewear from a designated selection every other Benefit Period	$0
Please consult your PEN Provider for information on discounts for which you may be eligible if you elect to receive eyewear/contact lenses outside the standard designated selection.	
(For Members outside of the South Carolina service area, $71 will be allowed toward the routine eye exam and a $120 credit will apply to the purchase of eyewear. Claims must be filed by the Member.)	

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The following benefits are covered outside of the BlueChoice Advantage Plus medical benefits.

BENEFITS	MEMBER PAYS
Employee Assistance Program (EAP Services)	
Individual & Family Counseling	
(visits 1-5)	$0
(visits 6-10)	$25 per visit
Life Management Services	
(5 visits)	$0
Benefits are provided under an agreement between First Sun EAP and the Employer. For services, please call 800-968-8143. First Sun EAP staff are available 24 hours a day, 7 days a week.	

- Members are not subject to the Pre-existing Condition exclusion.
- Dependents include children up to age 19 years and full-time students up to age 25 years.

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