



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	\$1,500	\$3,000 per individual
Per Family (All family Members can contribute with no one Member contributing more than the individual deductible amount.)	\$4,500	
Maximum Coinsurance per Benefit Period		
Per Member	\$2,500	\$5,000
Per Family	\$5,000	\$10,000

Services other than Mental Health and Substance Use Disorders

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS (Member must pay balance of Provider's Charge)
Primary Care		
Employee Health Clinic	\$0 (See flyer for details)	\$0 (See flyer for details)
Office services	\$35 per visit	Deductible, then 40%
Mandated Preventive Care	\$0	Not Covered
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	Not Covered
Routine Screening Mammogram	\$0	Not Covered
Routine Screening Colonoscopy	\$0	Not Covered
Maternity Care		
Routine Maternity Physician Services	Deductible, then 20%	Deductible, then 40%

In the event that one or more predications upon which this proposal is based are not met, BlueChoice HealthPlan reserves the right to modify the terms of this proposal in whole or in part or to revoke this proposal at its option. Coverage will not go into effect until these predications are met. If any other material changes occur in the information provided to BlueChoice HealthPlan, we may also revise the rates and benefits presented. These same assumptions will be conditions of renewal of your contract by BlueChoice HealthPlan.



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.

Services other than Mental Health and Substance Use Disorders

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS (Member must pay balance of Provider's Charge)
Inpatient Hospital/Facility Services (Authorization required)		
Admission (including maternity)	\$500 per admission, then 20%	Deductible, then 40%
Skilled Nursing Facility	Deductible, then 20%	Deductible, then 40%
Long-term Acute Care	Deductible, then 20%	Deductible, then 40%
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)
See Flyer for additional Savings		Covered only at a Participating Pharmacy
Value Generic drug and designated over-the-counter drug	\$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 will 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	

In the event that one or more predications upon which this proposal is based are not met, BlueChoice HealthPlan reserves the right to modify the terms of this proposal in whole or in part or to revoke this proposal at its option. Coverage will not go into effect until these predications are met. If any other material changes occur in the information provided to BlueChoice HealthPlan, we may also revise the rates and benefits presented. These same assumptions will be conditions of renewal of your contract by BlueChoice HealthPlan.



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.

Services other than Mental Health and Substance Use Disorders

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS (Member must pay balance of Provider's Charge)
Other Services		
Ambulance	Deductible, then 20%	Deductible, then 40%
Behavioral Therapy (ABA) for Autism Spectrum Disorder	Deductible, then 20%	Not Covered
Dental Services due to accidental injury	Deductible, then 20%	Not Covered
Durable Medical Equipment (DME)	Deductible, then 20%	Not Covered
Home Health	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%
Occupational Therapy	Deductible, then 20%	Not Covered
OP Private Duty Nursing	Deductible, then 20%	Deductible, then 40%
Physical Therapy	Deductible, then 20%	Not Covered
Speech Therapy	Deductible, then 20%	Not Covered
Chiropractic Services-\$1,000 maximum per Benefit period	\$50 per visit	Not Covered
Covered Transplants will be treated the same as any other medical condition. Services must be provided at a BlueChoice HealthPlan participating facility or a Blues Distinction for Transplant designated facility.		

In the event that one or more predications upon which this proposal is based are not met, BlueChoice HealthPlan reserves the right to modify the terms of this proposal in whole or in part or to revoke this proposal at its option. Coverage will not go into effect until these predications are met. If any other material changes occur in the information provided to BlueChoice HealthPlan, we may also revise the rates and benefits presented. These same assumptions will be conditions of renewal of your contract by BlueChoice HealthPlan.



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.

Mental Health & Substance Use Disorders

(The following services must be authorized in advance by Companion Benefit Alternatives at 1-800-868-1032)

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS (Member must pay balance of Provider's Charge)
Inpatient Hospital Facility Services	Deductible, then 20%	Deductible, then 40%
Inpatient Physician Services	Deductible, then 20%	Deductible, then 40%
Outpatient Facility Institutional Services	Deductible, then 20%	Deductible, then 40%
Outpatient Facility Professional Services	Deductible, then 20%	Deductible, then 40%
Office Professional Services	\$35 per visit	Deductible, then 40%
Urgent Care (does not require prior authorization)	Deductible, then 20%	Deductible, then 40%

Benefits not listed above will be covered the same as “Services other than Mental Health and Substance Use Disorders”

In the event that one or more predications upon which this proposal is based are not met, BlueChoice HealthPlan reserves the right to modify the terms of this proposal in whole or in part or to revoke this proposal at its option. Coverage will not go into effect until these predications are met. If any other material changes occur in the information provided to BlueChoice HealthPlan, we may also revise the rates and benefits presented. These same assumptions will be conditions of renewal of your contract by BlueChoice HealthPlan.



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
Annual Benefit Maximum	\$2,000,000	
Behavioral Therapy (ABA)	\$50,000 per Benefit Period	
Occupational Therapy	20 visits per Benefit Period	
OP Private Duty Nursing	60 visits per Benefit Period	
Physical Therapy	20 visits per Benefit Period	
Skilled Nursing Facility	120 days per Benefit Period	
Speech Therapy	20 visits per Benefit Period	
Chiropractic Care	\$1,000 per Benefit Period	
Benefit Period	Contract Year	

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.)	

In the event that one or more predications upon which this proposal is based are not met, BlueChoice HealthPlan reserves the right to modify the terms of this proposal in whole or in part or to revoke this proposal at its option. Coverage will not go into effect until these predications are met. If any other material changes occur in the information provided to BlueChoice HealthPlan, we may also revise the rates and benefits presented. These same assumptions will be conditions of renewal of your contract by BlueChoice HealthPlan.