

**Schedule of Benefits
Advantage Plus
Spartanburg County – 2010 Standard 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)	\$25 per visit	Deductible, then 40%
Hospital services	\$0	Deductible, then 40%
Specialty Care		
Office services	\$40 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	\$25 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%

In-Network Covered Services are underwritten by BlueChoice HealthPlan of South Carolina, Inc. Out-of-Network Covered Services are underwritten by BlueCross BlueShield of South Carolina and administered by BlueChoice HealthPlan of South Carolina, Inc.

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BENEFITS	In-Network MEMBER PAYS		Out-of-Network MEMBER PAYS
Outpatient/Ambulatory Care Facilities All services (including maternity)	\$250 per visit and 20% for first 3 visits per Benefit Period; 20% for visits 4 and up per Benefit Period		Deductible, then 40%
Emergency room services	\$125 per visit, then 20%		Same as In-Network
Urgent care	\$25 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 drug and designated over-the-counter drug	\$8	\$16	
Generic drug and designated over-the-counter drug	\$15	\$30	
Preferred brand-name drug	\$35	\$70	
Non-preferred brand-name drug	\$55	\$110	
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 Specialty Pharmaceuticals are administered as a Medical Benefit	\$100 Copayment		Not Covered

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BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
<p><u>Behavioral Health Services</u></p> <p>Mental Health Services</p> <p>State-Mandated Benefits for the following conditions:</p> <p>Autism Spectrum Disorder, Bipolar Disorder; Major Depressive Disorder; Obsessive Compulsive Disorder; Paranoid and other psychotic Disorders; Schizoaffective Disorder; Schizophrenia; Anxiety Disorder; Post-traumatic Stress Disorder; and Depression in childhood and adolescence.</p> <p>*See Other Services for Behavioral Therapy benefit</p> <p>For conditions not listed above</p> <p>Inpatient – 20 days per Benefit Period</p> <p>Outpatient – 20 visits per Benefit Period</p> <p>Substance Abuse Care</p> <p>Inpatient – 20 days per Benefit Period for detoxification only</p> <p>Outpatient – 20 combined visits per Benefit Period for detoxification and/or rehabilitation</p>	<p>(Authorization required)</p> <p>Same as for any other medical condition. Any day or visit limit shown in the Schedule of Benefits for Mental Health Services is not applicable to Covered Services for treatment of these conditions.</p> <p>\$500 per admission, then 20%</p> <p>\$40 per visit</p> <p>\$500 per admission, then 20%</p> <p>\$40 per visit</p>	<p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p>

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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	\$40 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	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
<p>Routine Vision Care - Physicians EyeCare Network (PEN) Providers Only (Refer to Provider Directory)</p> <p>One routine eye exam or one exam for contact lenses per Benefit Period</p> <p>One exam for contact lenses per Benefit Period</p> <p>One pair of eyewear or contact lenses from a designated selection every other Benefit Period</p> <p>(Other discounts and/or fees will apply to glasses and contact lenses outside of the designated selection.)</p> <p>(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.)</p>	<p>(Authorization not required)</p> <p>\$0</p> <p>\$45 (Fitting Fee)</p> <p>\$0</p>	<p>Not applicable unless the Member resides outside South Carolina</p>

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

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Employee Assistance Program (EAP Services) Individual & Family Counseling (visits 1-5) (visits 6-10) Life Management Services (5 visits) 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.	 \$0 \$25 per visit \$0	Not Covered

- ♦ 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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**Schedule of Benefits
Advantage Plus
Spartanburg County – 2010 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	\$500	\$1,000 per individual
Per Family (All family Members can contribute with no one Member contributing more than the individual deductible amount.)	\$1,500	
Maximum Coinsurance per Benefit Period		
Per Member	\$1,500	\$3,000
Per Family	\$3,000	\$6,000
Primary Care		
Office services (includes routine/preventive care)	\$25 per visit	Deductible, then 40%
Hospital services	\$0	Deductible, then 40%
Specialty Care		
Office services	\$40 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	\$25 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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Emergency room services	\$125 per visit, then 20%		Same as In-Network
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*See Other Services for Behavioral Therapy benefit		
For conditions not listed above		
Inpatient – 20 days per Benefit Period	\$500 per admission, then 20%	Not Covered
Outpatient – 20 visits per Benefit Period	\$40 per visit	Not Covered
Substance Abuse Care		
Inpatient – 20 days per Benefit Period for detoxification only	\$500 per admission, then 20%	Not Covered
Outpatient – 20 combined visits per Benefit Period for detoxification and/or rehabilitation	\$40 per visit	Not Covered

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