



Series II Plan Information – NEW PLANS

Carolina
ADVANTAGE

BlueChoice[®]
HealthPlan
South Carolina



An independent licensee of the
Blue Cross and Blue Shield Association

	Series II 100/60 – \$5,000		Series II 100/60 – \$8,000	
	In	Out	In	Out
Coinsurance	100%	60%	100%	60%
Deductible (3x)	\$5,000	\$5,000	\$8,000	\$9,000
Out-of-Pocket Maximum (2x)	N/A	\$5,000	N/A	\$6,000
Office Visits – Primary Care Physician	\$40	Deductible/Coinsurance	\$40	Deductible/Coinsurance
Office Visits – Specialists	\$70	Deductible/Coinsurance	\$70	Deductible/Coinsurance
Urgent Care	\$70	Deductible/Coinsurance	\$70	Deductible/Coinsurance
Hospitalization and Other Services	Deductible/Coinsurance	N/A	Deductible/Coinsurance	N/A
Emergency Room	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Rx with Mail Order (2.5x)	\$8/\$15/\$45/\$75	Not Covered	\$8/\$15/\$45/\$75	Not Covered
Specialty Rx	\$150/\$250	Not Covered	\$150/\$250	Not Covered
Rx Deductible Option	\$250		\$250	
EAP*	Yes		Yes	
Chiropractic	Yes		Yes	
Vision	No		No	
Preventive Dental	No		No	
	Series II 100/60 – \$10,000		Series II 70/50 – \$8,000	
	In	Out	In	Out
Coinsurance	100%	60%	70%	50%
Deductible (3x)	\$10,000	\$10,000	\$8,000	\$9,000
Out-of-Pocket Maximum (2x)	N/A	\$10,000	\$5,000	\$6,000
Office Visits – Primary Care Physician	\$40	Deductible/Coinsurance	\$40	Deductible/Coinsurance
Office Visits – Specialists	\$70	Deductible/Coinsurance	\$70	Deductible/Coinsurance
Urgent Care	\$70	Deductible/Coinsurance	\$70	Deductible/Coinsurance
Hospitalization and Other Services	Deductible/Coinsurance	N/A	Deductible/Coinsurance	N/A
Emergency Room	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Rx with Mail Order (2.5x)	\$8/\$15/\$45/\$75	Not Covered	BlueRx SM	Not Covered
Specialty Rx	\$150/\$250	Not Covered	\$150/\$250	Not Covered
Rx Deductible Option	\$250		None	
EAP*	Yes		Yes	
Chiropractic	Yes		Yes	
Vision	No		No	
Preventive Dental	No		No	
	Series II 70/50 – \$10,000		Series II 60/40 – \$3,000	
	In	Out	In	Out
Coinsurance	70%	50%	60%	40%
Deductible (3x)	\$10,000	\$10,000	\$3,000	\$6,000
Out-of-Pocket Maximum (2x)	\$7,000	\$10,000	\$4,000	\$8,000
Office Visits – Primary Care Physician	\$40	Deductible/Coinsurance	\$45	Deductible/Coinsurance
Office Visits – Specialists	\$70	Deductible/Coinsurance	\$75	Deductible/Coinsurance
Urgent Care	\$70	Deductible/Coinsurance	\$75	Deductible/Coinsurance
Hospitalization and Other Services	Deductible/Coinsurance	N/A	Deductible/Coinsurance	N/A
Emergency Room	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Rx with Mail Order (2.5x)	BlueRx	Not Covered	\$8/\$15/\$45/\$75	Not Covered
Specialty Rx	\$150/\$250	Not Covered	\$150/\$250	Not Covered
Rx Deductible Option	None		\$250	
EAP*	Yes		Yes	
Chiropractic	Yes		Yes	
Vision	No		No	
Preventive Dental	No		No	

* The EAP is offered by First Sun EAP. First Sun EAP is a separate company that does not offer BlueChoice HealthPlan products. These products are offered by First Sun EAP. BlueChoice HealthPlan has no responsibility for these products.

	Series II 60/40 – \$5,000		Series II 100/60 – HDHP – \$8,000	
	In	Out	In	Out
Coinsurance	60%	40%	100%	60%
Deductible (3x)	\$5,000	\$10,000	\$8,000	\$8,000
Out-of-Pocket Maximum (2x)	\$5,000	\$10,000	N/A	\$8,000
Office Visits – Primary Care Physician	\$45	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Office Visits – Specialists	\$75	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care	\$75	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Hospitalization and Other Services	Deductible/Coinsurance	N/A	Deductible/Coinsurance	N/A
Emergency Room	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Rx with Mail Order (2.5x)	BlueRx	Not Covered	BlueRx	Not Covered
Specialty Rx	\$150/\$250	Not Covered	Deductible/Coinsurance	Not Covered
Rx Deductible Option	None		None	
EAP*	Yes		Yes	
Chiropractic	Yes		No	
Vision	No		No	
Preventive Dental	No		No	
	Series II 70/50 – HDHP – \$10,000		Series II 100/60 – HDHP – \$10,000	
	In	Out	In	Out
Coinsurance	70%	50%	100%	60%
Deductible (3x)	\$10,000	\$10,000	\$10,000	\$10,000
Out-of-Pocket Maximum (2x)	\$5,000	\$10,000	N/A	\$10,000
Office Visits – Primary Care Physician	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Office Visits – Specialists	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Hospitalization and Other Services	Deductible/Coinsurance	N/A	Deductible/Coinsurance	N/A
Emergency Room	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Rx with Mail Order (2.5x)	BlueRx	Not Covered	BlueRx	Not Covered
Specialty Rx	Deductible/Coinsurance	Not Covered	Deductible/Coinsurance	Not Covered
Rx Deductible Option	None		None	
EAP*	Yes		Yes	
Chiropractic	No		No	
Vision	No		No	
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Office Visit Copayments

Covers all diagnostic and treatment services (including labs and X-rays) provided at a medical office of a participating primary care physician and other places as authorized by BlueChoice HealthPlan (diagnostic services, specialty providers, etc.) including preventive services, therapeutic procedures, surgical procedures, medical supplies, consultation and treatment.

**OB-GYN doctors are considered primary care physicians and would fall under the lower copayment.*

Preventive Services

Includes routine health screenings, well-baby and well-child care provided by in-network doctors with no dollar maximums or age limits.

Prescription Drugs

- Value Generics – \$8 copayment on any generic drug up to \$14.99
- Generic – \$15 copayment on any generic drug \$15 or higher
- \$45 brand-name drug
- \$75 non-preferred brand

**Value generic drugs are the lowest cost generic drugs on the market and also include the over-the-counter drugs currently covered by prescription.*

Value generic and generic drug copayments are not subject to the drug deductible.

Full mail order with copayments 2.5x the retail copayment on all plans for a 90-day supply.

Example: generic mail order (\$15 x 2.5) = \$37.50

Rx Deductibles (optional)

BlueRx

A discount program in which members pay the discounted rate for prescription drugs at participating network pharmacies. Drug costs go toward the deductible for any out-of-pocket maximum amount.

The 60/40 \$5K, 70/50 \$8K, 70/50 \$10K and 70/50 \$10K HDHP plans are not integrated. This means once the deductible is met, the member will still

need to pay his or her percentage of the discounted rate. BlueChoice HealthPlan will reimburse at the coinsurance amount.

The 100 percent \$8K and \$10K HDHP plans are integrated. Once a member meets his or her deductible for the benefit period, drug costs are covered at 100 percent.

Specialty Pharmaceutical

A copayment of \$150 on select specialty drugs and \$250 on all other specialty drugs that treat complex medical conditions.

Chiropractic Care

Automatically included (excluding HDHPs) and covered under the specialist copayment up to \$1,000 maximum per person per benefit period.

Occupational/Physical/Speech Therapy

20 visits per member per benefit period for each service.

Private Duty Nursing

Up to 60 days per benefit period.

Durable Medical Equipment

Subject to deductible and coinsurance.

Preventive Dental

No preventive dental coverage is available with these plans. Comprehensive dental is available as an optional add-on. See the information below.

Accidental Dental Services

Subject to deductible and coinsurance.

Vision

No vision coverage is available with these plans.

Routine Screening Mammogram

Covered at 100 percent at mammography network providers.

Routine Screening Colonoscopy

Covered at 100 percent at network providers.

Behavioral Health Services

Inpatient – 20 days per member per benefit period.

Outpatient – 20 visits per member per benefit period.

Comprehensive Dental – Optional Add-on

Service

Class I

Diagnostic and preventive, oral exam (one every six months), X-rays, emergency office visits

Class II

Basic dental, oral surgery and periodontic benefits (fillings, endodontics)

Class III

Prosthetic benefits (crowns and bridges)

Deductible

Classes II and III only

Maximum Benefit Payments

Benefit

100 percent of the allowable charge

80 percent of the allowable charge

50 percent of the allowable charge

\$50 (x3)

\$1,000 annual maximum