

BlueChoice® Individual Coverage Plan 7

BlueChoice HealthPlan of South Carolina, Inc.
Post Office Box 6170
Columbia, South Carolina 29260-6170
786-8476 in Columbia

Individual Health Maintenance Organization Coverage
Contract Form. No. CHCPOL.01

Outline of Coverage

If you need information about this health coverage:

Call BlueChoice HealthPlan's Member Services department. From Columbia, dial 786-8476. From anywhere else in the state, dial 800-868-2528, toll free. You may also send your inquiries through the Web site at www.BlueChoiceSC.com.

Read Your Contract Carefully

This Outline of Coverage provides a very brief description of the important features of BlueChoice Individual Coverage. This is not the contract and only the actual contract provisions will control the contract. The contract itself sets forth in detail the rights and obligations of you and BlueChoice HealthPlan. Please refer to your contract, which accompanies this Outline of Coverage. It gives special instructions on how to obtain authorization and how to handle an emergency.

Individual Health Maintenance Organization Coverage

BlueChoice Individual Coverage is specifically designed for you to use your primary care physician and other medical professionals with whom BlueChoice HealthPlan has a contract. All care must be provided by or authorized in advance by your primary care physician and BlueChoice HealthPlan except in a medical emergency. You must select a primary care physician from BlueChoice HealthPlan's list of participating primary care doctors. There are no claim forms when contracting doctors are used and few out-of-pocket expenses. Deductibles, copayments, coinsurance provisions or limitations set for in the contract are applicable.

Important

Here is the most important thing you need to remember about BlueChoice Individual Coverage:

All care, except for emergency services, must be provided by your primary care physician or authorized in advance by your primary care physician and BlueChoice HealthPlan.

Benefits Descriptions - Plan 7

Services

Benefits

Primary Care Physician Services Routine, Preventive Office Services	100% after Deductible 100% after \$35 Copayment per office visit
Inpatient Hospital Care	100% after Deductible
Outpatient Hospital Care	100% after Deductible
Specialist Physician Services	100% after Deductible
Urgent Care	100% after Deductible
Mental Health (office services only)	100% after Deductible
Prescription Drugs (Prescription drugs are each subject to one copayment for up to a 31-day supply)	100% after Deductible
Specialty Pharmaceuticals	100% after Deductible
Vision Care	One eye exam per Benefit Period
Dental Care	Up to \$20 for one exam and \$30 for one cleaning per Benefit Period
Deductible	\$5,000 per Benefit Period
Lifetime Maximum	\$2,000,000
Prescription Drug Maximum	Unlimited
Durable Medical Equipment Maximum	\$5,000 per Benefit Period
Physical Therapy, Speech Therapy, & Occupational Therapy Maximum	\$5,000 per Benefit Period
Coinsurance Maximum	Not Applicable

This is only a brief description of benefits. For a complete Schedule of Benefits, please refer to the contract.

Some Services And Supplies That Are Not Covered By BlueChoice Individual Coverage

There are some services and supplies that the person may receive which are not covered by BlueChoice Individual Coverage.

Listed below are a few examples of services and supplies which are not covered:

- Mental or emotional disorders, alcoholism and drug addiction except as provided under Mental Health Services. Treatment of Attention Deficit-Hyperactivity Disorder (ADHD) is not covered.
- Normal pregnancy and childbirth except for complications of pregnancy

For a complete listing of services and supplies that are not covered, please refer to the contract.

Pre-Existing Conditions

Pre-existing conditions are those conditions for which medical advice or treatment was received or recommended no more than 12 months prior to the effective date of your coverage. Services or supplies for pre-existing conditions are not covered until the earlier of:

1. A period of 12 months without medical care, treatment, or supplies related to the pre-existing condition ending after the effective date of coverage or
2. 12 months after the effective date of coverage.

Waiting Periods

After the effective date of your coverage under this contract, there are some waiting periods during which no coverage is provided for treatment of certain specified diseases or conditions or losses resulting therefrom. The waiting periods for this contract are stated below:

- Six months for adenoids
- Six months for appendix
- Six months for disorders of reproductive systems
- Six months for hemorrhoids
- Six months for hernia
- Six months for tonsils
- Six months for varicose veins

These waiting periods do not apply in case of an emergency if there is no previous medical history of the condition prior to the effective date of your coverage.

Guaranteed Renewable Except For Stated Reasons

The company shall renew or continue in force the contract at the person's option. The company may nonrenew or discontinue this contract based only on one of the following reasons:

- Failure to pay premiums
- Fraud or material misrepresentation
- Discontinuance of this type of coverage by the company
- The person no longer resides, works or lives in South Carolina
- The person reaches age 30

However, the company will not decline to renew the contract simply because of a health status-related factor. This is only a brief description. Please see the contract for more details on renewability, termination of coverage and conversion privileges.

Contract Term

This contract is renewable monthly up to age 30, subject to the renewal and termination provisions of this contract.

About Premiums

The company has the right to change the table of premiums on a class basis. If this table of premiums changes, the person will be notified at least 31 days in advance of the date that the change affects you. Note that the person's premium also changes as the person enters an older attained age group. If premiums change, the person pays the new rates the next time the premium is due.

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BlueChoice Individual Coverage
SCHEDULE OF BENEFITS – Plan 7

<p>In order to receive benefits, all care must be provided by the member's primary care physician or authorized in advance by the primary care physician and the company, unless otherwise noted. This applies to each and every individual service or treatment unless otherwise noted. Benefits are subject to all terms, conditions, limitations, exclusions and maximums in this contract.</p>		
Deductible per Benefit Period	\$5,000	
Maximum Coinsurance per Benefit Period	N/A	
BENEFITS	Member Pays	Plan Pays after copay/ deductible
Physician Services		
Primary Care		
Office Services	Deductible	100%
Routine, Preventive Services	\$35 Copayment per visit	100%
Hospital Services	\$0	100%
Specialty Care (except mental health/substance abuse care)		
Office Services	Deductible	100%
Hospital Services	Deductible	100%
Mental Health Benefits (office services only)	Deductible	100%
Other Services		
Ambulance	Deductible	100%
Durable Medical Equipment	Deductible	100%
Home Health	Deductible	100%
Hospice	Deductible	100%
Medical Supplies	Deductible	100%
OP Private Duty Nursing	Deductible	100%
Physical, Speech & Occupational Therapy	Deductible	100%
Prosthetic Devices	Deductible	100%
Facility Services		
Inpatient Hospital	Deductible	100%
Skilled Nursing Facility & Long-Term Acute Care Facility	Deductible	100%
Outpatient Services	Deductible	100%
Urgent Care Services – for services provided by a participating urgent care center	Deductible	100%
Emergency Room Services	Deductible	100%
Dental Services		
One exam per Benefit Period	100% after \$20	\$20
One cleaning per Benefit Period	100% after \$30	\$30

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SCHEDULE OF BENEFITS – Plan 7**

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BENEFITS	Member Pays	Plan Pays after copay/ deductible
<p>Vision Exam One complete eye exam for glasses per Benefit Period for services provided by participant in the Physicians Eye Network (PEN)</p>	\$0	100%
<p>Prescription Medication Generic Drugs Preferred Drugs Non-Preferred Drugs</p> <p>Retail pharmacy: Prescription Medications are each subject to one Copayment for up to a 31-day supply. Mail-order pharmacy: Prescription Medications are each subject to two Copayments for up to a 90-day supply. Not all medications are available from the mail-order pharmacy.</p>	Deductible	100%
<p>Specialty Pharmaceuticals Not subject to the Prescription Medication Maximum</p>	Deductible	100%
PLAN MAXIMUMS		
Lifetime Benefit Maximum	\$2,000,000	
Prescription Medication	None	
Durable Medical Equipment	\$5,000 per Benefit Period	
Physical, Speech & Occupational Therapy	\$5,000 per Benefit Period	
Organ Transplants (Covered Transplants)	Maximum Benefit per Transplant	
Kidney (single)	\$60,000	
Pancreas and Kidney	\$80,000	
Heart	\$120,000	
Lung (single)	\$130,000	
Liver	\$225,000	
Pancreas	\$80,000	
Heart and Lung	\$175,000	
Bone Marrow/Stem cell	\$250,000	
Cornea	\$25,000	
Lifetime Transplant Maximum Benefit	\$250,000	

The Benefit Period is 12 consecutive months from the effective date of coverage.