



Series III Plan Information

Carolina
ADVANTAGE



	Series III 70/50 – \$1,000		Series III 70/50 – \$1,500		Series III 70/50 – \$2,000		Series III 70/50 – \$2,500	
	In	Out	In	Out	In	Out	In	Out
Coinsurance	70%	50%	70%	50%	70%	50%	70%	50%
Deductible	\$1,000	\$2,000	\$1,500	\$3,000	\$2,000	\$4,000	\$2,500	\$5,000
Coinsurance Maximum	\$3,000	\$6,000	\$3,500	\$7,000	\$4,000	\$8,000	\$5,000	\$10,000
Office Visits – PCP	\$30	deductible/coinsurance	\$30	deductible/coinsurance	\$35	deductible/coinsurance	\$35	deductible/coinsurance
Office Visits – Specialists	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance
Mandated Preventive Care	\$0	not covered	\$0	not covered	\$0	not covered	\$0	not covered
Chiropractic Care	deductible/coinsurance	N/A	deductible/coinsurance	N/A	deductible/coinsurance	N/A	deductible/coinsurance	N/A
Vision	100%	N/A	100%	N/A	100%	N/A	100%	N/A
Urgent Care	\$50	deductible/coinsurance	\$50	deductible/coinsurance	\$50	deductible/coinsurance	\$50	deductible/coinsurance
ER	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance
Dental Preventive, one exam, initial/periodic	\$27/\$20		\$27/\$20		\$27/\$20		\$27/\$20	
Dental Preventive, one cleaning adult/child	\$40/\$31		\$40/\$31		\$40/\$31		\$40/\$31	
Rx (Retail)	\$8/\$15/\$35/\$55	N/A	\$8/\$15/\$35/\$55	N/A	\$8/\$15/\$35/\$55	N/A	\$8/\$15/\$35/\$55	N/A
Mail Order Rx	2.5X	N/A	2.5X	N/A	2.5X	N/A	2.5X	N/A
Specialty Rx	\$80/\$125	N/A	\$80/\$125	N/A	\$80/\$125	N/A	\$80/\$125	N/A
Rx Deductible Option	\$250		\$250		\$250		\$250	
	Series III 70/50 – \$3,000		Series III 70/50 – \$4,000		Series III 70/50 – \$5,000			
	In	Out	In	Out	In	Out		
Coinsurance	70%	50%	70%	50%	70%	50%		
Deductible	\$3,000	\$6,000	\$4,000	\$8,000	\$5,000	\$10,000		
Coinsurance Maximum	\$6,000	\$12,000	\$8,000	\$16,000	\$10,000	\$20,000		
Office Visits – PCP	\$35	deductible/coinsurance	\$35	deductible/coinsurance	\$35	deductible/coinsurance		
Office Visits – Specialists	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance		
Mandated Preventive Care	\$0	not covered	\$0	not covered	\$0	not covered		
Chiropractic Care	deductible/coinsurance	N/A	deductible/coinsurance	N/A	deductible/coinsurance	N/A		
Vision	100%	N/A	100%	N/A	100%	N/A		
Urgent Care	\$50	deductible/coinsurance	\$50	deductible/coinsurance	\$50	deductible/coinsurance		
ER	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance	deductible/coinsurance		
Dental Preventive, one exam, initial/periodic	\$27/\$20		\$27/\$20		\$27/\$20			
Dental Preventive, one cleaning adult/child	\$40/\$31		\$40/\$31		\$40/\$31			
Rx (Retail)	\$8/\$15/\$35/\$55	N/A	\$8/\$15/\$35/\$55	N/A	\$8/\$15/\$35/\$55	N/A		
Mail Order Rx	2.5X	N/A	2.5X	N/A	2.5X	N/A		
Specialty Rx	\$80/\$125	N/A	\$80/\$125	N/A	\$80/\$125	N/A		
Rx Deductible Option	\$250		\$250		\$250			



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
- \$35 Brand-name drug
- \$55 Non-preferred brand

**Value generic drugs are the lowest cost generic drugs on the market and also include the OTC 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)

Specialty Pharmaceutical

A copayment of \$80 on select specialty drugs and \$125 on all other specialty drugs that treat complex medical conditions.

Chiropractic Care

Automatically included and covered toward deductible/coinsurance 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

Automatically included in all CarolinaADVANTAGE plans and covers an allowed amount per benefit period for exams and cleanings at any licensed dentist.

Preventive Dental, one exam: initial \$27 / periodic \$20

Preventive Dental, one cleaning: adult \$40 / child \$31

Send a completed member claim form and the paid receipt to BlueChoice HealthPlan to be reimbursed for the allowed amount. The member claim form is available on our website, BlueChoiceSC.com, in the Members section under Forms.

Accidental Dental Services

Subject to deductible and coinsurance.

Vision

Automatically included and covers one eye exam each year and one pair of glasses or contact lenses every two years (PEN providers only)

Routine Screening Mammogram

Covered at 100 percent at mammography network provider

Routine Screening Colonoscopy

Covered at 100 percent at network provider.

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