

## State of SC – 2012

To receive benefits, the Member's Primary Care Physician must provide all care <b>or</b> the Primary Care Physician and Corporation must authorize all care in advance, unless otherwise noted. Benefits are subject to the terms of the Master Group Contract and the Certificate of Coverage.		
<b>BENEFITS</b>		
<b>Deductible per Calendar Year</b>		
Per Member	\$250	
Per Family	\$500	
<b>Maximum Coinsurance per Calendar Year</b>		
Per Member	\$2,000	
Per Family	\$4,000	
<b>Annual Benefit Maximum</b>	N/A – Unlimited	
	<b>Member Pays</b>	<b>Plan Pays</b> <i>after Copayment/Deductible</i>
<b>Physician Services</b>		
<b>Primary Care</b>		
Office visit	\$15 Copayment per visit	100%
Hospital visit	\$0	100%
Allergy injection and serum	\$15 Copayment per visit	100%
Routine physical exam	\$15 Copayment per visit	100%
Health assessment	\$15 Copayment per visit	100%
Well baby and child care	\$15 Copayment per visit	100%
Immunizations	\$15 Copayment per visit	100%
Routine mammogram	\$0	100%
<b>Specialty Care</b>		
Office visit	\$40 Copayment per visit	100%
Maternity care	\$40 Copayment first visit, and 15%	85%
Hospital Services	Deductible, then 15%	85%
Emergency room care	Deductible, then 15%	85%
Routine GYN exam – two per calendar year	\$15 Copayment per visit	100%
Chiropractic care	\$40 Copayment per visit	100%
\$1,000 maximum per calendar year		
<b>Facility Services</b> (all services must be preauthorized, except emergency care)		
Inpatient admission	\$200 Copayment per admission, and 15%	85%
Skilled Nursing Facility and/or Long-Term Acute Care Facility 120 days per calendar year	Deductible, then 15%	85%
Outpatient Services/Ambulatory Surgical Centers	\$100 Copayment and 15% per visit for first three visits per Benefit Period; 15% for visit four and each visit thereafter	85%
Emergency room services	\$125 Copayment per visit, and 15%	85%

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	Member Pays	Plan Pays <i>after Copayment/Deductible</i>
<b>Urgent Care</b> Inside the Local Service Area	\$35 Copayment per visit at a participating Urgent Care Provider	100%
<b>Prescription Medication (Generics First)</b> Value Generic Drug Generic Drug Preferred Brand-Name Drug Non-preferred Brand-Name Drug  <b>Prescription Medication dispensed by a retail pharmacy is subject to one Copayment for up to a 31-day supply. When a Participating Physician prescribes a Brand-Name Drug and indicates on the prescription that substitution of a Generic Drug is permitted, and there is an equivalent Generic Drug available, and the Member still requests the Brand-Name Drug, then any difference between the cost of the Generic Drug and the higher cost of the Brand-Name Drug will be the responsibility of the Member. This will be in addition to the Copayment appropriate to the Brand-Name Drug being purchased. In no instance will the Member be charged more than the actual retail price of the drug.</b>  Retail pharmacy: Quantity will be based on the lesser of the FDA-approved dosing guidelines or the BlueChoice HealthPlan Preferred Drug List.  <b>Unlimited maximum per Benefit Period.</b>	\$ 8 Copayment \$15 Copayment \$35 Copayment \$55 Copayment	100% 100% 100% 100%
<b>Mail-Order Prescription Medication (Generics First)</b> Value Generic Drug Generic Drug Preferred Brand-Name Drug Non-preferred Brand-Name Drug  <b>Prescription Medication dispensed by a mail-order pharmacy is subject to 2.5 Copayments for up to a 90-day supply.</b>  Mail-order pharmacy: Quantity will be based on the lesser of the FDA-approved dosing guidelines or the BlueChoice HealthPlan Preferred Drug List. Not all medications are available from the mail-order pharmacy. Refer to the BlueChoice HealthPlan Preferred Drug List for a list of the more common prescription drugs available through this pharmacy.  <b>Unlimited maximum per Benefit Period.</b>	\$20.00 Copayment \$37.50 Copayment \$87.50 Copayment \$137.50 Copayment	100% 100% 100% 100%
<b>Specialty Pharmaceuticals</b>  Preferred Drug Non-preferred Drug  <b>Prescription Medication dispensed by a mail-order pharmacy is subject to one Copayment per administration.</b>	\$80 Copayment \$125 Copayment	100% 100%

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	Member Pays	Plan Pays <i>after Copayment/Deductible</i>
<p><b>Behavioral Health Services</b> <b>(Referral/Authorization from Companion Benefit Alternatives [CBA] required)</b> <i>On behalf of BlueChoice HealthPlan, CBA manages behavioral health and substance abuse benefits for most of our members and their dependents. CBA is a separate company.</i></p> <p><b>Mental Health Services and Substance Abuse Care</b></p> <p>See <b>Other Services</b> for Behavioral Therapy benefit</p>	<p>Same as for any other medical condition</p>	
<p><b>Other Services</b></p> <ul style="list-style-type: none"> <li>Ambulance</li> <li>Behavioral Therapy (ABA) for Autism Spectrum Disorder – \$51,400 maximum per calendar year</li> <li>Home health</li> <li>Private duty nursing – up to 60 days per calendar year</li> <li>Hospice</li> <li>Initial prosthetic appliances</li> <li>Medical supplies</li> <li>Occupational therapy – 20 visits per calendar year</li> <li>Physical therapy – 20 visits per calendar year</li> <li>Speech therapy – 20 visits per calendar year</li> <li>Dental services due to accidental injury</li> <li>Durable Medical Equipment (DME)</li> </ul>	<ul style="list-style-type: none"> <li>Deductible, then 15%</li> <li>Deductible, then 15%</li> <li>Deductible, then 15%</li> <li>Deductible, then 15%</li> <li>Deductible, then 15%</li> <li>Deductible, then 15%</li> <li>Deductible, then 15%</li> <li>Deductible, then 15%</li> <li>Deductible, then 15%</li> <li>Deductible, then 15%</li> <li>Deductible, then 15%</li> <li>Deductible, then 15%</li> <li>Deductible, then 15%</li> <li>Deductible, then 15%</li> </ul>	<ul style="list-style-type: none"> <li>85%</li> <li>85%</li> <li>85%</li> <li>85%</li> <li>85%</li> <li>85%</li> <li>85%</li> <li>85%</li> <li>85%</li> <li>85%</li> <li>85%</li> <li>85%</li> <li>85%</li> <li>85%</li> </ul>
<p><b>Human Organ Transplants</b></p> <p>Covered transplants at Blue Distinction Centers of Excellence®: Kidney (single), Pancreas/Kidney, Heart, Lung (single), Lung (double), Liver, Pancreas, Heart/Lung, Bone Marrow/Stem Cell, and Cornea</p>	<p>\$200 copayment per admission, and 15%</p>	<p>85%</p>

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<b>Exclusions and Limitations</b>	<b>Pre-Existing Condition Limitations</b>
<p>Although this plan covers a broad range of services, there are exclusions and limitations. This is a list of some of these exclusions. For a complete list of all exclusions and limitations, see the Master Group Contract. All benefits are subject to the definitions, limitations and exclusions set forth in the Master Group Contract.</p> <ul style="list-style-type: none"> <li>◆ Services related to pregnancy of a dependent child except for complications of pregnancy. An abortion is not considered to be a complication of pregnancy.</li> <li>◆ Services, supplies and drugs related to any treatment for infertility or impotence.</li> <li>◆ Services and supplies for dental work or treatment, unless it results from an accident.</li> <li>◆ Services and supplies related to dysfunctional conditions of the muscles of mastication, malpositions or deformities of the jaw bone(s), orthognathic deformities, or temporomandibular joint disorders (TMJ).</li> <li>◆ Organ transplants other than those listed in the Schedule of Benefits.</li> <li>◆ Charges for acquisition for storage of organs for human organ transplants.</li> <li>◆ Services and supplies related to plastic or cosmetic surgery, unless medically necessary and due to an accident, surgery or congenital anomaly.</li> <li>◆ Services, supplies or drugs for treatment of morbid obesity or for other weight control disorders, including gastric bypass or stapling, intestinal bypass, and any related procedures including reversal.</li> <li>◆ Eyeglasses, contact lenses and hearing aids, unless specified in the Schedule of Benefits.</li> <li>◆ Therapy for learning disability and speech delay, stuttering, perceptual disorders, mental retardation, behavioral disorders, vocational rehabilitation and marriage counseling.</li> <li>◆ Removal of teeth, whether impacted or not.</li> </ul>	<p>A Pre-existing Condition is defined as a physical or mental condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the Enrollment Date. Enrollment Date means the date of enrollment in the plan or coverage or, if earlier, the first day of the Waiting Period to become eligible for such enrollment. Pregnancy is not a Pre-existing Condition.</p> <p>This plan has a Pre-existing Condition exclusion period, which is the period an individual must wait before benefits are paid for a Pre-existing Condition, if any. Specifically, this Plan’s Pre-existing Condition exclusion period may extend for no more than 12 months without medical care, treatment or supplies, ending after the Member’s Effective Date, or no more than 12 months after the Enrollment Date, whichever comes first. The Pre-existing Condition exclusion period for a Late Enrollee may extend for no more than 18 months after the Enrollment Date.</p> <p>The Pre-existing Condition exclusion period may be reduced by a period of Creditable Coverage. A representative of the group’s Human Resources department may be contacted for a further explanation of Creditable Coverage.</p>