



Series II Plan Information

Carolina
ADVANTAGE



	Series II 80/60 – \$250		Series II 80/60 – \$500		Series II 80/60 – \$750		Series II 80/60 – \$1,000	
	In	Out	In	Out	In	Out	In	Out
Coinsurance	80%	60%	80%	60%	80%	60%	80%	60%
Deductible	\$250	\$500	\$500	\$1,000	\$750	\$1,500	\$1,000	\$2,000
Coinsurance Maximum	\$1,500	\$3,000	\$2,000	\$4,000	\$2,500	\$5,000	\$2,500	\$5,000
Office Visits – PCP	\$20	deductible/coinsurance	\$25	deductible/coinsurance	\$30	deductible/coinsurance	\$30	deductible/coinsurance
Office Visits – Specialists	\$35	deductible/coinsurance	\$40	deductible/coinsurance	\$45	deductible/coinsurance	\$45	deductible/coinsurance
Mandated Preventive Care	\$0	not covered	\$0	not covered	\$0	not covered	\$0	not covered
Chiropractic Care	\$35	deductible/coinsurance	\$40	deductible/coinsurance	\$45	deductible/coinsurance	\$45	deductible/coinsurance
Vision	100%	N/A	100%	N/A	100%	N/A	100%	N/A
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	
Urgent Care	\$50	deductible/coinsurance	\$50	deductible/coinsurance	\$50	deductible/coinsurance	\$50	deductible/coinsurance
Other Services	deductible/coinsurance	N/A	deductible/coinsurance	N/A	deductible/coinsurance	N/A	deductible/coinsurance	N/A
ER	\$125 + 80% coinsurance	\$125 + 80% coinsurance	\$125 + 80% coinsurance	\$125 + 80% coinsurance	\$125 + 80% coinsurance	\$125 + 80% coinsurance	\$125 + 80% coinsurance	\$125 + 80% coinsurance
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	\$100		\$100		\$100		\$150	
	Series II 80/60 – \$1,500		Series II 80/60 – \$2,000		Series II 80/60 – \$2,500		Series II 70/50 – \$750	
	In	Out	In	Out	In	Out	In	Out
Coinsurance	80%	60%	80%	60%	80%	60%	70%	50%
Deductible	\$1,500	\$3,000	\$2,000	\$4,000	\$2,500	\$5,000	\$750	\$1,500
Coinsurance Maximum	\$3,000	\$6,000	\$3,500	\$7,000	\$4,000	\$8,000	\$2,500	\$5,000
Office Visits – PCP	\$30	deductible/coinsurance	\$35	deductible/coinsurance	\$35	deductible/coinsurance	\$30	deductible/coinsurance
Office Visits – Specialists	\$45	deductible/coinsurance	\$50	deductible/coinsurance	\$50	deductible/coinsurance	\$45	deductible/coinsurance
Mandated Preventive Care	\$0	not covered	\$0	not covered	\$0	not covered	\$0	not covered
Chiropractic Care	\$45	deductible/coinsurance	\$50	deductible/coinsurance	\$50	deductible/coinsurance	\$45	deductible/coinsurance
Vision	100%	N/A	100%	N/A	100%	N/A	100%	N/A
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	
Urgent Care	\$50	deductible/coinsurance	\$50	deductible/coinsurance	\$50	deductible/coinsurance	\$50	deductible/coinsurance
Other Services	deductible/coinsurance	N/A	deductible/coinsurance	N/A	deductible/coinsurance	N/A	deductible/coinsurance	N/A
ER	\$125 + 80% coinsurance	\$125 + 80% coinsurance	\$125 + 80% coinsurance	\$125 + 80% coinsurance	\$125 + 80% coinsurance	\$125 + 80% coinsurance	\$150 + 70% coinsurance	\$150 + 70% coinsurance
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		\$100	
	Series II 70/50 – \$1,000		Series II 70/50 – \$1,500		Series II 70/50 – \$2,000		Series II 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	\$2,500	\$5,000	\$3,000	\$6,000	\$3,500	\$7,000	\$4,000	\$8,000
Office Visits – PCP	\$30	deductible/coinsurance	\$30	deductible/coinsurance	\$35	deductible/coinsurance	\$35	deductible/coinsurance
Office Visits – Specialists	\$45	deductible/coinsurance	\$45	deductible/coinsurance	\$50	deductible/coinsurance	\$50	deductible/coinsurance
Mandated Preventive Care	\$0	not covered	\$0	not covered	\$0	not covered	\$0	not covered
Chiropractic Care	\$45	deductible/coinsurance	\$45	deductible/coinsurance	\$50	deductible/coinsurance	\$50	deductible/coinsurance
Vision	100%	N/A	100%	N/A	100%	N/A	100%	N/A
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	
Urgent Care	\$50	deductible/coinsurance	\$50	deductible/coinsurance	\$50	deductible/coinsurance	\$50	deductible/coinsurance
Other Services	deductible/coinsurance	N/A	deductible/coinsurance	N/A	deductible/coinsurance	N/A	deductible/coinsurance	N/A
ER	\$150 + 70% coinsurance	\$150 + 70% coinsurance	\$150 + 70% coinsurance	\$150 + 70% coinsurance	\$150 + 70% coinsurance	\$150 + 70% coinsurance	\$150 + 70% coinsurance	\$150 + 70% coinsurance
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	\$150		\$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 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

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



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

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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



High Deductible Health Plan Information

Carolina
ADVANTAGE



	HDHP		HDHP		HDHP		HDHP		HDHP		HDHP	
	In	Out	In	Out	In	Out	In	Out	In	Out	In	Out
Deductible per Benefit Period												
Single Coverage	\$1,500	\$2,000	\$2,000	\$2,500	\$2,750	\$3,500	\$5,000	\$5,000	\$2,750	\$3,500	\$3,750	\$4,250
Family Coverage*	\$3,000	\$4,000	\$4,000	\$5,000	\$5,500	\$7,000	\$10,000	\$10,000	\$5,500	\$7,000	\$7,500	\$8,500
<i>*For family coverage, benefits are not payable until the entire family deductible has been met.</i>												
Coinsurance												
<i>After the deductible, all covered expenses are paid as follows except for in-network, routine, Preventive Services:</i>												
For Medical Expenses												
BlueChoice HealthPlan pays	80%	60%	80%	60%	80%	60%	100%	60%	100%	60%	100%	60%
Member pays	20%	40%	20%	40%	20%	40%	\$0	40%	0%	40%	0%	40%
For Prescription Medications												
BlueChoice HealthPlan pays	80%	Not covered	80%	Not covered	80%	Not covered	100%	Not covered	100%	Not covered	100%	Not covered
Member pays	20%		20%		20%		\$0		0%		0%	
Maximum Out-of-Pocket per Benefit Period												
Single Coverage	\$4,500	\$9,000	\$5,000	\$10,000	\$5,000	\$10,000	\$5,000	\$10,000	\$2,750	\$10,000	N/A	\$5,750
Family Coverage	\$9,000	\$18,000	\$10,000	\$20,000	\$10,000	\$20,000	\$10,000	\$20,000	\$5,500	\$20,000	N/A	\$11,500
Mandated Preventive Care	\$0	Not covered	\$0	Not covered	\$0	Not covered	\$0	Not covered	\$0	Not covered	\$0	Not covered
Office Services (All other)	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Routine Screening Mammograms and Routine Screening Colonoscopies	Not subject to deductible and coinsurance	Not covered	Not subject to deductible and coinsurance	Not covered	Not subject to deductible and coinsurance	Not covered	Not subject to deductible and coinsurance	Not covered	Not subject to deductible and coinsurance	Not covered	Not subject to deductible and coinsurance	Not covered
	Member pays: \$0		Member pays: \$0		Member pays: \$0		Member pays: \$0		Member pays: \$0		Member pays: \$0	
Hospital Admissions	Authorization required	Authorization required	Authorization required	Authorization required	Authorization required	Authorization required	Authorization required	Authorization required	Authorization required	Authorization required	Authorization required	Authorization required
Urgent Care	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Mental Health/ Substance Abuse Care												
Limited to crisis intervention for mental health services and detoxification for substance abuse.	Authorization required	Not covered	Authorization required	Not covered	Authorization required	Not covered	Authorization required	Not covered	Authorization required	Not covered	Authorization required	Not covered

All plans have an in-network and out-of-network deductible for both single and family coverage. For family coverage, each deductible is a combined deductible for all covered family members. After a deductible is met, we pay according to the corresponding coinsurance amount. Each plan has a different coinsurance amount for in-network providers and out-of-network providers. When covered members use in-network providers and hospitals, their out-of-pocket costs are lower and their deductible also applies to their out-of-pocket maximum. Routine preventive office services, such as well-baby/child care, immunizations, annual physicals, Pap smears, routine GYN exams and prostate screenings, are covered as part of your benefit package.

Other Covered Services

After members meet their deductibles, we pay according to the plan's coinsurance amounts for the many services including:

- Daily medical visits and consultations in a hospital or skilled nursing facility
- Surgery, anesthesia, labs, X-rays and routine maternity services
- Lab work, X-rays and other diagnostic services at a hospital outpatient department, clinic or doctor's office
- Second surgical opinions
- Professional ambulance services
- Medical supplies, prosthetics and oxygen
- Home Health and Hospice care
- Accidental dental services
- Durable medical equipment

Occupational/Physical/Speech Therapy

20 visits per member per benefit period for each service.

Private Duty Nursing

Up to 60 days per benefit period.

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. Chiropractic Care is excluded.

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.

Prescription Drug Coverage

Members can save on all their covered prescription drugs when they use our national network of pharmacies. After members meet their in-network deductibles, we will pay according to the plan's coinsurance amount. Our pharmacies will file the claims for them.

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

Prosthodontic 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