BlueChoice HealthPlan South Carolina
An independent licensee of the Blue Cross and Blue Shield Association

Non-Grandfathered

Schedule of Benefits
BlueChoice Advantage Plus^SM
Hospice of the Upstate

In order to receive In-Network benefits, all services must be provided by a BlueChoice HealthPlan Participating Provider. This applies to each individual service unless otherwise noted. All admissions must be authorized by BlueChoice HealthPlan in order to be covered. Benefits are subject to all terms, conditions, limitations, and exclusions outlined in the Contract.

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
Deductible per Benefit Period		
Per Member	$2,000	$4,000
Per Family (All family Members can contribute with no one Member contributing more than the individual deductible amount.)	$4,000	$8,000
Maximum Out-of-Pocket per Benefit Period (includes deductible, coinsurance and all copays)		
Per Member	$5,000	$12,000
Per Family	$10,000	$24,000

Services other than Mental Health and Substance Use Disorders

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS (Member must pay balance of Provider's Charge)
Primary Care		
Office services	$30 per visit	Deductible, then 50%
Mandated Preventive Care	$0	Not Covered
Specialty Care		
Office services	$60 per visit	Deductible, then 50%
Hospital services (includes inpatient, outpatient & ambulatory care services)	Deductible, then 30%	Deductible, then 50%
Emergency room care	Deductible, then 30%	Deductible, then 30%
Other Routine Care		
GYN Exam – 2 per Benefit Period	$0	Deductible, then 50%
Routine Screening Mammogram	$0	Deductible, then 50%
Routine Screening Colonoscopy	$0	Deductible, then 50%
Maternity Care		
Routine Maternity Physician Services (no additional copay for ongoing routine care)	Deductible, then 30%	Deductible, then 50%

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Services other than Mental Health and Substance Use Disorders

BENEFITS	In-Network MEMBER PAYS		Out-of-Network MEMBER PAYS (Member must pay balance of Provider's Charge)
Inpatient Hospital/Facility Services (Authorization required)			
Admission (including maternity)	Deductible, then 30%		Deductible, then 50%
Skilled Nursing Facility	Deductible, then 30%		Deductible, then 50%
Long-term Acute Care	Deductible, then 30%		Deductible, then 50%
Outpatient/Ambulatory Care Facilities			
All outpatient services (including maternity)	Deductible, then 30%		Deductible, then 50%
Emergency room services	$350 per visit, then 30%		Same as In-Network
Ambulatory Surgical Center	$60 per visit		Deductible, then 50%
Urgent care	$40 per visit		Deductible, then 50%
Prescription Medicine	Retail (up to a 31-day supply)	Mail Order (up to a 90-day supply)	Covered only at a Participating Pharmacy
Tier 1	$8	$20.00	
Tier 2	$25	$62.50	
Tier 3	$45	$112.50	
Tier 4	$70	$175.00	
No max per Benefit Period	You will have to pay more if you select a non-generic drug instead of its less-expensive Covered generic drug (or Covered over the counter) alternative.		
Tier 5	$125	$312.50	Not Covered
Tier 6	$175	$437.50	
No max per Benefit Period • Specialty medications are not available through the mail order program for a 90-day supply. This only applies to generic or brand drugs in these tiers.	Not Covered: Drugs designated as excluded on the Prescription Drug List.		

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Services other than Mental Health and Substance Use Disorders

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS (Member must pay balance of Provider's Charge)
Other Services		
Ambulance	Deductible, then 30%	Deductible, then 50%
Behavioral Therapy (ABA) for Autism Spectrum Disorder	Deductible, then 30%	Not Covered
Dental Services due to accidental injury	Deductible, then 30%	Not Covered
Durable Medical Equipment (DME)	Deductible, then 30%	Not Covered
Home Health	Deductible, then 30%	Deductible, then 50%
Hospice	Deductible, then 30%	Deductible, then 50%
Initial Prosthetic Appliances	Deductible, then 30%	Deductible, then 50%
Medical Supplies	Deductible, then 30%	Deductible, then 50%
Occupational Therapy	Deductible, then 30%	Not Covered
Outpatient Private Duty Nursing	Deductible, then 30%	Deductible, then 50%
Physical Therapy	Deductible, then 30%	Not Covered
Speech Therapy	Deductible, then 30%	Not Covered
Chiropractic Services		
Manipulation	$60 per visit	Not Covered
All Other Services	Deductible, then 30%	Not Covered

Covered Transplants will be treated the same as any other medical condition. Services must be provided at a BlueChoice HealthPlan participating facility or a Blues Distinction for Transplant designated facility.

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Mental Health & Substance Use Disorders

(Companion Benefit Alternatives, Inc. (CBA) must authorize these services in advance. On behalf of BlueChoice HealthPlan, CBA manages behavioral health and substance abuse benefits for our members and their dependents. CBA is a separate company. Call CBA at 1-800-868-1032)

BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS (Member must pay balance of Provider's Charge)
Inpatient Hospital Facility Services	Deductible, then 30%	Deductible, then 50%
Inpatient Physician Services	Deductible, then 30%	Deductible, then 50%
Outpatient Facility Institutional Services	Deductible, then 30%	Deductible, then 50%
Outpatient Facility Professional Services	Deductible, then 30%	Deductible, then 50%
Office Professional Services (does not require prior authorization)	$30 per visit	Deductible, then 50%
Urgent Care (does not require prior authorization)	Deductible, then 30%	Deductible, then 50%

Benefits not listed above will be covered the same as "Services other than Mental Health and Substance Use Disorders"

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MAXIMUMS	
Occupational Therapy	20 visits per Benefit Period
Outpatient Private Duty Nursing	60 visits per Benefit Period
Physical Therapy	20 visits per Benefit Period
Skilled Nursing Facility	120 days per Benefit Period
Speech Therapy	20 visits per Benefit Period
Benefit Period	Calendar Year

BENEFITS	MEMBER PAYS
Routine Vision Care - Physicians EyeCare Network (PEN) Providers Only (Refer to Provider Directory)	**(Authorization not required)**
One routine eye exam or one exam for contact lenses per Benefit Period	$0
One standard contact lens fitting per Benefit Period	$45
One pair of eyewear from a designated selection every other Benefit Period	$0
Please consult your PEN Provider for information on discounts for which you may be eligible if you elect to receive eyewear/contact lenses outside the standard designated selection.	
(For Members outside of the South Carolina service area, $71 will be allowed toward the routine eye exam and a $120 credit will apply to the purchase of eyewear. Claims must be filed by the Member.)	

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The following benefits are covered outside of the BlueChoice Advantage Plus medical benefits.

BENEFITS	MEMBER PAYS
Employee Assistance Program (EAP Services)	
Individual & Family Counseling (visits 1-3)	$0
Life Management Services (3 visits)	$0
Benefits are provided under an agreement between First Sun EAP and the Employer. First Sun EAP is a separate company that does not offer BlueChoice HealthPlan products. These services are offered by First Sun EAP, not BlueChoice HealthPlan. BlueChoice HealthPlan has no responsibility for these services. For services, please call First Sun EAP at 1-800-968-8143. First Sun EAP staff are available 24 hours a day, 7 days a week.	

- Nurseline
- Personal Health Assessment

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Financial Proposal

Advantage Plus
Hospice of the Upstate

Plan Design:	Advantage Plus	70%/50%
Funding Arrangement:	Fully-Insured - Replacement	
Proposed Effective Date:	8/1/2017 - 07/31/2018	
Date Issued:	July 13, 2017	Quote ID: 107211 - 2

Coverage Type - Medical

Tiers	# of Eligible Employees	Monthly Premiums
Employee	51	$572.00
Employee/Family	11	$1,543.75

Proposal Qualifications:

- Employees eligible to be enrolled are those full-time active employees who work at least 30 hours per week.
- BlueChoice HealthPlan is being offered on a carrier replacement basis.
- BlueChoice Health Plan reserves the right to adjust rates from the audit date back to the effective date if any of the following occur:
- Demographic Factor +/-10%, Average Contract Size +/-10% or participation falls below 70%.
- Employee eligibility lag is FOM following 60 days.
- This proposal is based on the employee census data and other information provided by Hospice of the Upstate. We reserve the right to recalculate rates if there is more than a 10% +/- variance in enrollment, or receipt of additional information.
- Coverage will be provided upon completion and acceptance of the group contract.
- Customized reports and materials, such as provider directories and ID cards, may be subject to additional charges.
- This proposal provides a summary of the BlueChoice HealthPlan benefits. Please consult the Master Group Contract for a complete detailed listing of benefits, terms, conditions, exclusions and limitations.
- Additional funding underneath deductible or coinsurance is required to be disclosed. Failure to disclose additional funding may result in higher than anticipated rate adjustments.
- BlueChoice HealthPlan utilizes an on-line billing system, Quickbill, to transmit all monthly premium invoices.
- Employer Contribution being at least 75% towards single tier unless previously documented.
- This health coverage does meet the minimum value standard for the benefits it provides.
- A minimum of 70% participation is required excluding valid waivers unless previously documented. At least 50% of total eligible employees must enroll with BlueChoice HealthPlan regardless of waivers.
- BlueChoice HealthPlan reserves the right to adjust rates from the audit date back to the effective date if any of the following occur: Demographic Factor +/- 10%, Average Contract Size +/- 10% or participation falls below 70%.
- Rates are valid for 30 days from the date issued indicated above. Rates are subject to change beyond this 30 day period.

In the event that one or more predications upon which this proposal is based are not met, BlueChoice HealthPlan reserves the right to modify the terms of this proposal in whole or in part or to revoke this proposal at its option. Coverage will not go into effect until these predications are met. If any other material changes occur in the information provided to BlueChoice HealthPlan, we may also revise the rates and benefits presented. These same assumptions will be conditions of renewal of your contract by BlueChoice HealthPlan.