I want affordable health care coverage.

This is my plan.

Personal Blue℠ Basic

PLAN FEATURES ▪ Fixed plan designs offer lower premiums and solid benefits.

- Eight plan designs to choose from with five deductible levels
- Three benefit levels and three out-of-pocket maximums
- Prescription drug coverage available
- Lifetime benefit maximum of $2 million
- Access to the largest preferred provider network in South Carolina

PLAN OPTIONS ▪ Want to add extra benefits to your plan?

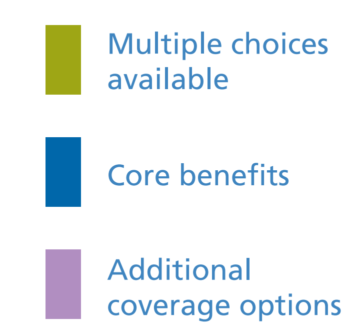
- Maternity coverage
- Supplemental accident coverage
- Combined dental and vision benefits

These are the details.

You want an affordable health care plan, without sacrificing quality coverage. Personal Blue Basic gives you peace of mind and the security that comes with the BlueCross BlueShield of South Carolina name.

As a BlueCross member, you're covered by the largest statewide network of providers. Your BlueCross card also gives you access to providers across the nation with our BlueCard® program.

Our affordable plan designs, outstanding network value and commitment to member service make Personal Blue Basic the right choice for you.



Choose my plan

Select one plan from the list of options below.

	Copayment for Office Visits*	Single Deductible*		Family Deductible*	
		In-Network	Out-of-Network	In-Network	Out-of-Network
❑ Plan 1	$15 Primary Care $25 Specialist	$500	$1,500	$1,500	$4,500
❑ Plan 2	$15 Primary Care $25 Specialist	$500	$1,500	$1,500	$4,500
❑ Plan 3	$15 Primary Care $25 Specialist	$1,000	$3,000	$3,000	$9,000
❑ Plan 4	$15 Primary Care $25 Specialist	$1,000	$3,000	$3,000	$9,000
❑ Plan 5	$15 Primary Care $25 Specialist	$1,500	$4,500	$4,500	$13,500
❑ Plan 6	$15 Primary Care $25 Specialist	$1,500	$4,500	$4,500	$13,500
❑ Plan 7	Deductible/ Coinsurance	$2,500	$5,000	$5,000	$10,000
❑ Plan 8	Deductible/ Coinsurance	$5,000	$10,000	$10,000	$20,000

Benefit Percentage	Single Out-of-Pocket Maximum*		Family Out-of-Pocket Maximum*	
	In-Network	Out-of-Network	In-Network	Out-of-Network
80/60	Unlimited	Unlimited	Unlimited	Unlimited
60/40	$5,000	$10,000	$10,000	$20,000
80/60	$5,000	$10,000	$10,000	$20,000
60/40	$5,000	$10,000	$10,000	$20,000
80/60	$6,000	$12,000	$12,000	$24,000
60/40	$6,000	$12,000	$12,000	$24,000
80/60	$7,500	$15,000	$15,000	$30,000
70/50	Unlimited	Unlimited	Unlimited	Unlimited

** Copayments and deductibles do not feed out-of-pocket maximum.*

Choose my Drug Coverage

Choose one

❑ **Drug Card ($8/30/60 copayments)**
Specialty drug copayment is 10 percent of allowable charges to a maximum of $200 for a 31-day supply. Mail-order copayments are $16/70/140 for up to a 90-day supply. Out-of-network coverage is paid at out-of-network benefit percentage.

❑ **Secure Card* ($10/45/75 copayments)**
Specialty drug copayment is 20 percent of allowable charges for a 31-day supply. Mail-order copayments are $25/115/190 for up to a 90-day supply. Requires use of generics where available. For brands with generic equivalent medications, the member will pay the difference in allowable charges between generic and brand medications after the copayment.

❑ **Basic Card* ($15/60/75 copayments)**
Specialty drug copayment is 50 percent of allowable charges for a 31-day supply. Mail-order copayments are $25/115/190 for up to a 90-day supply. Uses the Basic preferred drug list (PDL). Members may only use Step One medications where available. For Step Two medications, the member is responsible for 100 percent of allowable charges unless prior authorization is obtained or member uses step therapy.

❑ **Generic Card***
Generic only coverage with $10 copayments for up to a 31-day supply; $20 copayment for up to a 90-day supply through the mail. Also includes some diabetic medications. Discount card for non-covered drugs.

❑ **Blue Rx℠ Express**
Paid at allowable charges after member meets deductible and pays coinsurance. Specialty drug copayment is 10 percent of allowable charges to a maximum of $200. Mail-order medications are available. Out-of-network coverage is paid at out-of-network benefit percentage.

** No coverage out-of-network. Prescription drug copayments do not apply toward the medical deductible or any out-of-pocket maximum.*

Preventive Screenings

Pap smear, prostate screening, lab work and routine mammogram are covered at 100 percent in-network only. Any associated office visit charge is subject to either an office visit copayment or deductible and coinsurance, described separately. Colorectal screenings covered with deductible and coinsurance.

Physician Services

We pay covered physician services at the plan's in- or out-of-network benefit percentages, including:

- Daily medical visits and consultations in a hospital or facility
- Medical, lab work, X-rays and other diagnostic services at a hospital outpatient department, clinic or doctor's office
- Initial exam of a newborn baby and nursery charges if newborn is added to member's coverage within 31 days
- All other covered physician services

All benefits are subject to any applicable copayment, deductible and coinsurance, unless otherwise indicated.

Copayments

In-Network Office Visits (Plans 1–6)
$15 per visit to primary care physician.
$25 per visit for specialist.

The office visit copayment applies only to the office charge. Other services provided during the office visit are subject to the deductible and coinsurance. Preventive screening services (described separately) are covered at 100 percent (in-network only). Copayments do not apply to optional maternity coverage, mental health services or substance abuse care.

For plans 7 and 8, allowable charges for office visits are subject to the deductible and coinsurance.

Emergency Room (all plans, in- or out-of-network) – $150 copayment for treatment in an emergency room (waived if admitted to hospital the same day for same condition — inpatient copayment will be applied instead).

Outpatient Hospital (all plans, in- or out-of-network) – $200 copayment for each outpatient hospital admission.

Inpatient Hospital (all plans, in- or out-of-network) – $300 copayment for each inpatient hospital admission.

Copayments do not apply toward any deductible or coinsurance. All charges after copayment are subject to deductible and coinsurance.

Outpatient Hospital Services

We pay allowable charges for covered outpatient hospital services including:

- Hospital, ambulatory surgical center or clinic charges
- Emergency room facility charges
- Medical and surgical services
- Preadmission testing, lab work, X-rays and other diagnostic services
- All other covered outpatient services

Inpatient Hospital Services

We pay allowable charges including:

- Semi-private room and board, or special care unit
- All other covered hospital services, including surgical services and anesthesia
- Inpatient rehabilitation, limited to $5,000 per member, per benefit period, with a $100,000 lifetime benefit

Requires preadmission review, emergency admission review and continued stay review for medically necessary treatment fee all hospital admissions.

All benefits are subject to any applicable copayment, deductible and coinsurance, unless otherwise indicated.

Physical Therapy	Allowable charges, up to $500 per member, per benefit period.
Diabetic Supplies and Dialysis	Allowable charges are paid subject to deductible and coinsurance.
Home Health and Hospice	Allowable charges are paid, subject to deductible and coinsurance, to a maximum of $10,000 per benefit period for all home health and hospice services combined.
Lifetime Benefit Maximum	$2,000,000 per member.
Transplant Services	Human organ and tissue transplants, subject to transplant and lifetime maximums; services must be pre-authorized.
Dental Accident Coverage	Benefits for dental services related to an accident, if provided within 12 months of accident (limited to $1,000 per tooth, $3,000 per member, per benefit period).
Durable Medical Equipment (DME)	We pay allowable charges to a maximum of $2,500 per member each benefit period; pre-authorization is required for any benefit of $500 or more. Members may only obtain one rental/purchase for each type of DME per benefit period.
Skilled Nursing Facility	Semi-private room and board, to maximum of $2,500 per member, per benefit period. Admission must be within 14 days from hospital discharge. Preapproval is required.
Orthotics and Ostomy Supplies	Allowable charges are covered to a combined maximum of $1,500 per benefit period, subject to deductible and coinsurance.
Mental Health and Substance Abuse Services	Allowable charges up to $2,000 per member, per benefit period, with a $10,000 lifetime limit for all mental health and substance abuse services, including inpatient, outpatient, physician services and prescription medications. All benefits are subject to any applicable copayment, deductible and coinsurance.

All benefits are subject to any applicable copayment, deductible and coinsurance, unless otherwise indicated.

Here are the options.

❑ Optional Maternity Coverage

We pay allowable charges at the percent shown based on the length of time maternity coverage is in effect, only for a member or a covered spouse. Includes maternity services, surgery, anesthesia, lab work and X-rays in a hospital or at a hospital outpatient department, ambulatory surgical center, clinic or doctor's office.

During the first 12 months – we pay allowable charges at 5 percent

13th month through the 24th month – we pay allowable charges at 60 percent

25th month through the 36th month – we pay allowable charges at 80 percent

37th month and after – we pay allowable charges at 100 percent

❑ Combined Dental and Vision Benefit

Dental

Class I Preventive Care – 100 percent of allowed charges*

- Checkups and cleaning: One every six months
- Bite-wing X-rays: One set per benefit period
- Emergency treatment for pain (subject to $300 limit)

Class II Restorative Care – 50 percent of allowed charges*

- Simple and surgical teeth removal (not including impacted teeth)
- Fillings
- Anesthesia
- Oral surgery

Vision

- Eye exam: 100 percent of allowed charges**
- Frames and lenses or contact lenses: 100 percent of allowed charges**
- Discounts also available to members with Vision One

** Combined maximum of $300 dental benefit per benefit period.*

*** $100 maximum per eye exam, per benefit period. $50 maximum payment per member, per benefit period for frames and lenses or contact lenses.*

Dental/Vision level of coverage must match level of health coverage chosen.

❑ Supplemental Accident Coverage

Pays first dollar benefits up to $500 per member, per benefit period for covered services due to accidental injury. Amounts over $500 are subject to deductible and coinsurance.

Plus...

My Health Toolkit

Our members enjoy the convenience of 24-hour access to information on benefits, claims and personal health information by using My Health Toolkit℠, located at www.SouthCarolinaBlues.com.

My Health Toolkit also features a physician finder, hospital comparison tool, treatment and drug cost estimators, and access to a health library.

Out-of-Area Coverage

The BlueCard and BlueCard Worldwide® give members access to participating doctors and hospitals across the country and around the world. You have peace of mind knowing you're covered if you get sick or injured while traveling outside of South Carolina.

It's as easy as showing your BlueCross ID card to a participating provider. No matter where you travel, your BlueCross coverage goes with you.

Money Saving Network

Our statewide network includes more than 9,000 doctors, more than 4,000 other providers and all of South Carolina's acute care hospitals. The combination of access and discount value is unbeatable. Members also have access to every Blue Cross and Blue Shield plan's provider network in the country. Finding a doctor or hospital in our network is simple and saves money.

Discount and Value-Added Programs

We are always looking for ways to make your health care dollars go further. Our members enjoy discounts on non-covered services such as fitness and weight loss programs, cosmetic surgery, vision correction, healthy reading materials and much more.

Learn more about our discount and value-added programs at www.SouthCarolinaBlues.com.

Exclusions for Personal Blue Basic

- Any services or benefits which are not specifically covered under the terms of this policy, or which were received before this policy went into effect or after it terminates.
- Services or charges for which the member is entitled to payment or benefits from other sources (workers' compensation or auto insurance), or for which the member is not legally obligated to pay, including treatment provided in a government hospital or benefits provided under Medicare or other governmental programs (except Medicaid).
- Separate charges for services provided by employees of hospitals, laboratories or other institutions; services or supplies performed or furnished by a member of the covered person's immediate family; and services for which a charge is normally not made in the absence of insurance.
- Normal pregnancy or childbirth, except as provided when the Optional Maternity Coverage is purchased; routine nursery charges.
- Cosmetic surgery, or surgery or treatment for the purpose of weight reduction, including any complications from or reversal of these procedures, or reconstructive procedures made necessary by weight loss.
- Illness contracted or injury sustained as the result of war or act of war (whether declared or undeclared), or participation in a felony, riot or insurrection.
- Admissions for sanitarium care or rest cures, long-term residential psychiatric care, custodial care and nursing homes.
- Refractive care, such as radial keratotomy, laser eye surgery or LASIK.
- Services or treatments that are not medically necessary.
- Sterilization, reversal of sterilization, infertility or impotency treatment, or treatment of sexual dysfunction for the enhancement of sexual performance or transsexual procedures.
- Dental care or treatment, except as provided in your policy and as shown in your Schedule of Benefits.
- Hearing aids and examinations for their prescribing or fitting.
- Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.
- Treatment, services or supplies received as a result of suicide, attempted suicide or intentionally self-inflicted injuries.
- Spinal subluxation.
- Treatment for temporomandibular joint disorders (TMJ), including office visits, splints, braces, guards, etc., except for medically necessary surgical correction.
- Treatment for injuries resulting from intoxication over the legal limit as specified by state law or resulting from the influence of any narcotic or drug, unless taken on the advice of a physician.
- Services or benefits for any pre-existing condition (a condition not revealed on your application and for which you had symptoms or had previously received medical advice or treatment).

This is a list of some of our exclusions. For a full list of excluded services and supplies, or for all limitations, please refer to your policy.

This is where I go if I have a question.

If you have a question or need help, contact your local BlueCross BlueShield of South Carolina agent, call us at 800-451-4275 or visit us online at SouthCarolinaBlues.com.

SouthCarolinaBlues.com

VISIT US ONLINE AT SouthCarolinaBlues.com

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

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