

I want a health  
care plan with all  
the options.



South Carolina

# These are my plans.

## Personal BluePlans<sup>SM</sup>

**PLAN FEATURES** ■ Personal BluePlans let you build the plan that works for you. The choice is yours.

- Choice of seven deductible levels, ranging from \$250 to \$5,000
- Four benefit levels and four out-of-pocket maximum options
- Prescription drug coverage (Plans 1 and 2 only)
- Lifetime benefit maximum of \$2 million
- Access to the largest preferred provider network in South Carolina

**PLAN OPTIONS** ■ Want to add some extra coverage? Here are some more great options.

- Office visit copayment
- Maternity coverage
- Dental coverage
- Supplemental accident coverage




# These are Plans 1 and 2.


If you want more complete coverage, these are the plans for you. You can choose to have an office visit copayment or cover those services under your coinsurance — it's up to you.

Whatever you decide, you'll be covered by the largest statewide network of providers. Our BlueCard® and BlueCard Worldwide® programs keep you covered across the country and around the world. And, if you should ever need assistance, our team of member service representatives is here for you.

Affordable plan designs, outstanding network value and commitment to member service make Blue the right choice for you.

 Multiple choices available

 Core benefits

 Additional coverage options

## Deductible Choices (per member per benefit period)

*Choose one deductible level*

- \$250
- \$500
- \$1,000
- \$1,500
- \$2,000
- \$3,000
- \$5,000 (not available on Plan 1)

## Benefit Options

*Choose one coverage level*

### In-Network/Out-of-Network

- 90/70%
- 80/60%
- 70/50%
- 60/40%

## Out-of-Pocket Maximums

*Choose one*

### In-Network/Out-of-Network

- \$1,500/\$3,000
- \$2,500/\$5,000
- \$3,000/\$6,000
- \$5,000/\$8,000

## Choose my Drug Coverage

*Choose one*

### Blue Rx<sup>SM</sup>

Allowable charges paid at benefit percentage after member meets deductible and pays coinsurance. Specialty drug copayment is 10 percent with a maximum of \$200 at specialty network provider only.

### Drug Card (\$8/30/60 copayments)

Specialty drug copayment is 10 percent of allowable charges to a maximum of \$200 at specialty network provider only.

## Copayment Options

*Choose one*

### \$35 for primary care physician / \$60 for specialists (Plan 1)

### No copayment (Plan 2)

When the office visit copayment option is selected, the following services in the physician's office are covered after the applicable copayment: treatment of illness, accident or injury; injections for allergy, tetanus or antibiotics; diagnostic lab and diagnostic X-rays (chest and plain film), when performed in the doctor's office on the same date and billed by the doctor.

Copayments do not apply to maternity (when purchased), mental health services or substance abuse care. All other services are subject to the deductible and coinsurance.

If you select the copayment option (Plan 1), you also receive certain well-child benefits. Please refer to the Preventive Services section for more information on this coverage.

## Physician Services

After members meet their benefit period deductible, we pay covered physician services at the plan's in- or out-of-network benefit percentages. Covered services include:

- 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
- Surgery
- Second surgical opinions
- All other covered physician services

## Outpatient Hospital Services

After members meet their benefit period deductible, we pay allowable charges for covered outpatient hospital services at the plan's in- or out-of-network benefit percentages. Covered services include:

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

*All benefits are subject to any applicable deductible and coinsurance, unless otherwise noted.*

## Preventive Screenings

With Personal BluePlan 1, your preventive screenings, such as Pap smear, prostate screening and lab work, are covered at 100 percent after copayment, in network only. With Personal BluePlan 2, these screenings are covered subject to your deductible and at the coinsurance amount selected. For both plans, mammography is paid at 100 percent when members use our special mammography network. Colorectal screenings are covered with deductible and coinsurance.

If copayment option is selected, Plan 1 also includes well-child checkups (age 1 through age 6) and immunizations beginning at age 1 according to the American Academy of Pediatrics guidelines.

## Inpatient Hospital Services

We pay allowable charges, subject to coinsurance at in-network facilities. If members use an out-of-network facility, there is also an inpatient copayment, and the members must meet their deductible both in- and out-of-network.

- Semi-private room and board, or special care unit
- All other covered hospital services, including surgical services and anesthesia
- Inpatient rehabilitation, with a lifetime maximum of \$100,000 per member

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

## Transplant Services

Human organ and tissue transplants, subject to transplant and lifetime maximums; services must be pre-authorized. Benefits are subject to all applicable copayments, deductible and coinsurance.

<b>Lifetime Benefit Maximum</b>	\$2,000,000 per member.
<b>Dental Accident Coverage</b>	Benefits to cover dental services related to an accident, if provided within 12 months of accident. Subject to all required copayments, deductible and coinsurance.
<b>Durable Medical Equipment</b>	We pay allowable charges subject to deductible and coinsurance; pre-authorization must be obtained for any benefit of \$100 or more. Includes ostomy supplies and orthotics.
<b>Diabetic Supplies and Dialysis</b>	Allowable charges are paid subject to deductible and coinsurance.
<b>Physical and Speech Therapy</b>	Allowable charges, subject to deductible and coinsurance, up to \$1,000 per member, per benefit period.
<b>Skilled Nursing Facility</b>	We pay allowable charges subject to deductible and coinsurance; admission must be within 14 days from hospital discharge. Preapproval is required.
<b>Home Health and Hospice</b>	We pay allowable charges subject to deductible and coinsurance; must receive preapproval.
<b>Mental Health and Substance Abuse Services</b>	Allowable inpatient and outpatient charges up to a \$10,000 lifetime limit. All benefits are subject to applicable copayments, deductible and coinsurance.

*All benefits are subject to any applicable deductible and coinsurance, unless otherwise noted.*

# These are Plans 3 and 4.

If you're looking for health care coverage with lower premiums, these are the plans for you. Choose outpatient and inpatient coverage with Plan 3 or inpatient coverage only with Plan 4.

These plans provide peace of mind and the same great network, value and outstanding service you expect from BlueCross.

 Multiple choices available

 Core benefits

 Additional coverage options

## Deductible Choices (per member per benefit period)

*Choose one deductible level*

- \$250
- \$500
- \$1,000
- \$1,500
- \$2,000
- \$3,000
- \$5,000

## Benefit Options

*Choose one coverage level*

### In-Network/Out-of-Network

- 90/70%
- 80/60%
- 70/50%
- 60/40%

## Out-of-Pocket Maximums

*Choose one*

### In-Network/Out-of-Network

- \$1,500/\$3,000
- \$2,500/\$5,000
- \$3,000/\$6,000
- \$5,000/\$8,000

## Physician Services

After members meet their benefit period deductible, we pay covered physician services at the plan's in- or out-of-network benefit percentages. Applies only where services are provided on an inpatient basis (Plans 3 and 4) or in an outpatient facility (Plan 3). Covered services include:

- Outpatient services, including treatment of accidents
- Medical, lab work, X-rays and other diagnostic services at a hospital outpatient department when members are admitted to the hospital within 14 days after they receive services and the admission is for a related cause
- Surgery, including administration of anesthesia
- Second surgical opinions
- Daily medical visits and consultations in a hospital or facility

## Outpatient Hospital Services

*(only available with Personal BluePlan 3)*

After members meet their benefit period deductible, we pay allowable charges for covered outpatient hospital services at the plan's in- or out-of-network benefit percentages. Covered services include:

- Hospital, ambulatory surgical center, or clinic charges
- Medical and surgical services
- All other covered outpatient services

## Inpatient Hospital Services

We pay allowable charges, subject to the deductible and coinsurance, at in-network facilities. If members use an out-of-network facility, there is also an inpatient copayment, and the members must meet their deductible both in- and out-of-network.

- Semi-private room and board, or special care unit
- All other covered hospital services, including surgical services and anesthesia
- Chemotherapy, inhalation therapy, physical therapy and radiation therapy, when received on an inpatient basis (Plans 3 and 4) or outpatient basis (Plan 3) only
- Inpatient rehabilitation, with a lifetime maximum of \$100,000 per member

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

## Preventive Screenings

*(only available with  
Personal BluePlan 3)*

On Personal BluePlan 3, mammography is covered at members' coinsurance percentage after they meet their deductible.

Colorectal screening is covered at the coinsurance percentage after members meet their deductible.

## Transplant Services

Inpatient and outpatient admissions for human organ and tissue transplants, subject to transplant and lifetime maximums; services must be pre-authorized. Benefits are subject to all applicable copayments, deductible and coinsurance.

## Lifetime Benefit Maximum

\$2,000,000 per member.

## Dental Accident Coverage

Benefits to cover dental services related to an accident, if provided within 12 months of accident. Subject to all required copayments, deductible and coinsurance. Applies only where services are provided on an inpatient basis (Plans 3 and 4) or an outpatient basis (Plan 3).

## Diabetic Supplies and Dialysis

Dialysis is covered under Plan 3 if received on an outpatient basis. It is covered under Plan 4 if received on an inpatient basis. Allowable charges are paid subject to deductible and coinsurance.

## Diagnostic Hospital Services

Preadmission testing, lab work, X-rays and other diagnostic services when the member is admitted to the hospital within 14 days after the services are received and the admission is for a related cause.

## Mental Health and Substance Abuse Services

Allowable charges up to a \$10,000 lifetime limit. All benefits are subject to applicable copayments, deductible and coinsurance. Applies only where services are provided on an inpatient basis (Plans 3 and 4) or in an outpatient facility (Plan 3).

*All benefits are subject to any applicable deductible and coinsurance, unless otherwise noted.*



# Here are the options.

## □ **Dental Coverage**

Pays 80 percent of allowable charges on preventive care (Class I), 60 percent of allowable charges on restorative care (Class II) and 40 percent on major restorative care (Class III). Class II and Class III benefits are subject to a \$25 deductible per member, per benefit period. All dental services are limited to \$500 per member, per benefit period. A 12-month waiting period applies to Class III services.

## □ **Optional Maternity Coverage**

*(only available on Personal BluePlans 1 and 2)*

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** – no benefit

**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

## □ **Supplemental Accident Coverage**

Pays first dollar benefits up to \$500 of allowable charges per member, per benefit period for covered services due to accidental injury. Amounts over \$500 of allowable charges 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<sup>SM</sup>, located at [www.SouthCarolinaBlues.com](http://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

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](http://www.SouthCarolinaBlues.com).

## Exclusions for Personal BluePlans

- Any services or benefits which are not specifically covered under the terms of the policy, or which were received before the 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, or routine nursery charges, except as provided when the Optional Maternity Coverage is purchased.
- 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 the policy and shown on the 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 injuries resulting from intoxication 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).

NOTE: For Personal BluePlan 3, benefits are limited as described in this brochure, to services provided on an inpatient or outpatient basis. For Personal BluePlan 4, benefits are limited to services received on an inpatient basis only.

*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.*



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# 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](https://SouthCarolinaBlues.com).



[SouthCarolinaBlues.com](https://SouthCarolinaBlues.com)

VISIT US ONLINE AT [SouthCarolinaBlues.com](http://SouthCarolinaBlues.com)



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