

**I want a health  
care plan that  
balances coverage  
and cost.**



**South Carolina**

# This is my plan.

## Personal Blue<sup>SM</sup> Secure

**PLAN FEATURES** ■ With slightly higher deductible choices, you can lower your premium costs — without sacrificing your benefits.

- Choice of six deductible levels, starting at \$1,250 and up to \$5,250 (single coverage, in-network)
- Four benefit levels and four out-of-pocket maximum options
- Choice of prescription drug benefits
- Lifetime benefit maximum of \$2 million
- Access to the largest preferred provider network in South Carolina

**PLAN OPTIONS** ■ Want to feel even more secure about your coverage? Enhance the standard plan with increased benefits.

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




# These are the details.

You want affordable health care coverage that still has the benefits you need. Personal Blue Secure offers you the coverage you want, with more affordable premiums.

You'll also get the peace of mind that comes with the BlueCross BlueShield of South Carolina name. As a BlueCross member, you're covered by the largest statewide network of providers. And, you have 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 Secure the right choice for you.

 Multiple choices available

 Core benefits

 Additional coverage options

## Deductible Choices (per member per benefit period)

*Choose one deductible level*

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

- \$1,250/\$2,500
- \$1,750/\$3,500
- \$2,250/\$4,500
- \$3,250/\$6,500
- \$4,250/\$8,500
- \$5,250/\$10,500

The in-network deductibles and out-of-network deductibles are separate and do not accumulate to each other or to the out-of-pocket maximum.

## Benefit Options

*Choose one coverage level*

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

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

## Out-of-Pocket Maximums

*Choose one*

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

- \$1,750/\$3,500
- \$2,250/\$4,500
- \$3,750/\$7,500
- \$5,250/\$10,500

The in-network and out-of-network out-of-pocket amounts are separate amounts and do not accumulate to each other.

## 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 up to 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 up to 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 up to 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<sup>SM</sup> 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 for up to a 31-day supply. 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.*

## Copayments

### In-Network Office Visits

\$40 per visit to primary care physician.

\$65 per visit for specialist.

The first four office visits each benefit period (in-network, all types combined) will be covered with a copayment. Services included in the physician's office charge: 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. Other covered services, or office visit charges out-of-network, are subject to the deductible and coinsurance. After the fourth visit, allowable charges will be covered subject to the deductible and coinsurance for the rest of that benefit period. Copayments do not apply to optional maternity coverage, mental health services or substance abuse care. For preventive office visits, the copayment applies only to the office charge.

## Copayments

*(continued)*

**Emergency Room** – \$150 for treatment in an emergency room, then member pays deductible and coinsurance. Copayment waived if admitted to hospital same day for same condition – inpatient copayment will be applied.

**Inpatient Hospital** – \$300 inpatient hospital admission, then member pays deductible and coinsurance.

Copayments do not apply toward any deductible, coinsurance or out-of-pocket maximum. All charges after copayment are subject to deductible and copayment.

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

## Preventive Screenings

Pap smear, prostate screening, lab work and routine mammogram are covered at 100 percent in-network only. Office visits for these screenings are subject to the office visit copayment. Colorectal screenings are covered with deductible and coinsurance.

## 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
- Emergency room facility charges (copayment applies)
- 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, subject to members' applicable copayment, deductible and coinsurance.

- Semi-private room and board, or special care unit
- All other covered hospital services, including surgical services and anesthesia
- Inpatient rehabilitation, limited to \$10,000 per member, per benefit period, with a \$100,000 lifetime benefit

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

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

# 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

## □ **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.

## □ **Combined Dental and Vision Benefit**

### **Dental**

Class I Preventive Care – 100 percent of allowed charges\*

- Checkups: Every six months
- Cleaning: 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

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

### **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 through our value-added program

\*\* \$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.

# 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

The BlueCard and BlueCard Worldwide<sup>®</sup> 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 Blue Secure

- 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, 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 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 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](https://SouthCarolinaBlues.com).



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

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