Blue Option℠

Individual and Family Health Insurance Plans for South Carolinians

BlueChoice® HealthPlan

NEW & IMPROVED PRODUCTS!
VISION & DENTAL COVERAGE FOR ALL!

Blue Option Individual Plans

There are many factors to consider when choosing a health plan. What works for one person or family may not be right for another. Rest assured that BlueChoice HealthPlan is here to help you evaluate your options and make the best choice.

Blue Option plans provide individual and family coverage. Whether you need a policy for yourself or for all the members of your family, we have a plan that fits.

Why Choose Blue Option?

BlueChoice HealthPlan has more than 30 years of experience providing South Carolinians like you with health care coverage. Our service, value and quality are evident in our Blue Option plans. We offer a range of plans that meet the requirements of the Affordable Care Act (ACA) and keep you covered.

- 23 plan designs – four Gold, twelve Silver, six Bronze plans and one "Under 30" Catastrophic plan
- Deductible and copayment amounts that help you manage your health care costs
- Statewide doctor and hospital network
- No referrals for specialists needed
- Plans with low drug deductibles
- Preventive dental and adult vision care
- Preventive services with $0 copayment
- Nationally recognized health plan for service and member satisfaction

Blue Option Network

Our philosophy ... keeping you healthy.

BlueChoice® emphasizes preventive medicine, early disease detection and prompt treatment. We base this approach on the personal relationship between the patient and the doctor. This special relationship helps keep you healthy.

Though it is not required, we encourage you to choose a primary care physician (PCP). Having one doctor who can help you manage your health care is important to your overall health. You do not need referrals to specialists. Your PCP can, however, help coordinate care when you need to visit one of our network specialists.

We work hard to ensure that your providers give you and your family the best care possible. And we make it simple — no paperwork, no referrals and no surprises. The Blue Option network is an exclusive provider organization and includes:

- Affordable copayments or coinsurance per visit after meeting your deductible
- No claim forms or referrals needed for specialists
- No charge for certain preventive care, including routine annual exams and screenings
- Freedom to select your own providers of care within our statewide network
- Worldwide coverage for emergency care

Special "Under 30" Plan

We offer a "catastrophic plan" option for adults under 30. It is also available to those eligible for a hardship exemption. These exemptions include events such as a recent family death, a bankruptcy filing in the last six months, or fire or flood damage to your property.

Superior Service and Quality

In today's world, feeling secure is important. With Blue Option health coverage from BlueChoice, you are covered by a company that's been doing business with South Carolinians since 1984.

Our commitment to our members has earned us accreditation from the National Committee for Quality Assurance, a national group that reviews health plans. This means we passed the test in critical areas of health plan operations. We value this award and consistently work to improve our service and maintain this status. We're even more pleased that thousands of South Carolinians select us as their health plan.

Making the Right Choice

The ACA required most Americans to purchase health insurance as of April 2014. You may wonder why — especially if you are young or very healthy. BlueChoice wants to help you understand the changes of health care reform and the importance of quality health care coverage.

Why You Need Health Insurance

Health insurance is a service you pay for, but hope you never need. Our members value health care coverage. They value the peace of mind they have knowing it's there. It is a safety net for the unpredictable and uncontrollable problems that come up in life. BlueChoice encourages you to consider these factors when deciding whether to buy health insurance.

Financial Impact

You may be healthy now, but a sudden or serious illness can leave you with staggering medical bills. The inability to pay high medical bills is one of the most common reasons people file for personal bankruptcy. This can ruin your credit history and set you back financially for years.

Choosing to forgo health insurance means you must pay all of your health care costs. From doctors' visits, health screenings and checkups to ambulance rides and trips to the emergency room, you are responsible. You also won't have any protection against astronomical medical bills — such as a $30,000 bill for a three-day hospital stay.

Preventive or Primary Care

The ACA requires coverage for annual checkups and preventive care — mammograms, vaccinations, colonoscopies and prostate cancer screenings — without a copayment. Preventive care helps you stay healthy and catch health problems early. That's when they're easier and less expensive to treat.

Policies also must provide a minimum standard of care known as essential health benefits, in 10 categories:

- Preventive and wellness services
- Ambulatory (outpatient) care services
- Emergency care
- Hospitalization
- Maternity and newborn care
- Pediatric care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services (specialized therapies and medical equipment to help people facing long-term disabilities)
- Laboratory services

Follow-up Care

Hospital emergency rooms traditionally care for patients with urgent needs regardless of their ability to pay. But necessary follow-up care, rehabilitative care or other services can be very expensive without coverage.

Delay in Getting Coverage

If you wait too long to decide, you may face a delay before getting the coverage you and your family need. Typically, you can only purchase health insurance during open enrollment periods. You may also be able to enroll within 30 days of life-altering events, such as marriage, divorce, birth of a child or change in job status. Open enrollment for coverage effective January 1, 2015, begins November 15, 2014. Open enrollment ends February 15, 2015.

Non-Enrollment Tax Implications

If you are required to purchase health insurance and have not done so by February 15, 2015, you will receive a penalty on your 2015 tax return (filed in 2016). The penalty in 2014 is $325.00 per adult and $162.50 per child. The fee is capped at $975 per family, or 2 percent of household income. Each year the penalty increases. In 2016, the fine rises to $695 per adult and will be capped at $2,085 per family, or 2.5 percent of income. There is no penalty for a gap in coverage for less than three months.

Can I Afford Health Insurance?

The real question is: Can you afford not to have health care coverage? We realize that cost is important, but there is good news. For the first time in history, people with moderate and low incomes will be eligible for financial assistance. Tax credits and subsidies will help offset the cost of premiums and out-of-pocket expenses. This assistance applies to plans sold in the BlueChoice HealthPlan private exchange or federal health insurance marketplace.

Who Is Eligible?

Premium tax credits are income-based. Individuals and families whose income falls between 100 and 400 percent of the federal poverty line are eligible. Here are some examples:

- Individual $11,670 to $46,680 annual income
- Family of four $23,850 to $95,400 total household income

You cannot get premium credits if you are eligible for Medicare or Medicaid. If your employer offers coverage, you are not eligible for premium credits unless that coverage is inadequate or if it costs more than 9.5 percent of your annual income.

Premium credits are also available to legal immigrants who have incomes below 100 percent of the poverty line, but who are not eligible for Medicaid because they have lived in the United States for less than five years.

How Much Is the Premium Credit?

The premium credit is figured on a sliding scale. Those with lower incomes receive a bigger credit and those who make more get a smaller one. The credits ensure that you do not have to pay more than a certain percentage of your income to purchase health insurance. For example, someone with an income of two times the poverty line (about $23,000) would pay no more than 6.3 percent of that income. That would be about $121 a month for an individual policy.

What Kind of Health Plan Can Someone Buy With the Credit?

BlueChoice will offer three types of plans in the exchange — Bronze, Silver and Gold. These plans vary in the level of benefits covered. Bronze plans are the least comprehensive and Gold plans are the most comprehensive.

The amount of the premium credit is based on the cost of the second-lowest cost silver plan available in the area in which the person receiving the subsidy lives. You can purchase a more comprehensive plan, such as a Gold plan, but will have to pay the difference between the credit amount and the cost of the more expensive plan. You also could purchase a less expensive plan, but you would not receive a credit for more than the cost of the plan.

How Do the Premium Credits Work?

The premium credits will be delivered as tax credits and will be available to everyone who is eligible, whether they file taxes or not. The credits will be paid directly to the insurer, with individuals responsible for the remaining premiums. The credits will be delivered in advance, so that people do not have to pay all of their premiums up front and wait for reimbursement.

Who Is Eligible for Cost-Sharing Assistance?

People who earn less than 250 percent of the poverty line ($29,175 for an individual, $59,625 for a family of four) will also receive additional assistance. These cost-sharing subsidies help ensure that everyone can afford the health care they need.

How Does the Cost-Sharing Assistance Work?

The premium credits allow people to buy a Silver plan, which has a 70 percent actuarial value. That means that the plan will cover 70 percent of the costs for covered medical services with the beneficiary, on average, paying the other 30 percent. People who receive cost-sharing assistance, however — those with incomes below 250 percent of the poverty line — will not have to pay the full remaining 30 percent of the cost of covered services. As a result, people with incomes below 250 percent of poverty will effectively be enrolled in a plan that has a higher actuarial value than 70 percent.

For example, people with incomes below 150 percent of the poverty line will have plans that have an actuarial value of 94 percent. Plans for people with incomes between 150 percent and 200 percent of the poverty line will have an actuarial value of 87 percent. These higher actuarial values mean that as a result of cost-sharing assistance, low-income individuals and families will be able to enroll in health plans with lower deductibles, copayments and/or total out-of-pocket costs.

Glossary

Affordable Care Act (ACA) — The health care reform law. This law was passed in two parts. The Patient Protection and Affordable Care Act became law on March 23, 2010. This law was amended by the Health Care and Education Reconciliation Act on March 30, 2010. Affordable Care Act refers to the final, amended version of the law. Some people also call this law Obamacare.

Coinsurance — The dollar amount or percentage you pay for your covered health care services. For example, if you have an "80/20" plan, your health plan would pay 80 percent of the bill and you would pay 20 percent. The 20 percent you pay is your coinsurance.

Coinsurance Maximum — The total amount you pay out of pocket per benefit period including copayments and deductibles.

Copayment — A set dollar amount you pay each time you receive a health care service. For example, your health plan may have a $20 copayment for a doctor's office visit. You will pay this amount each time you go to the doctor.

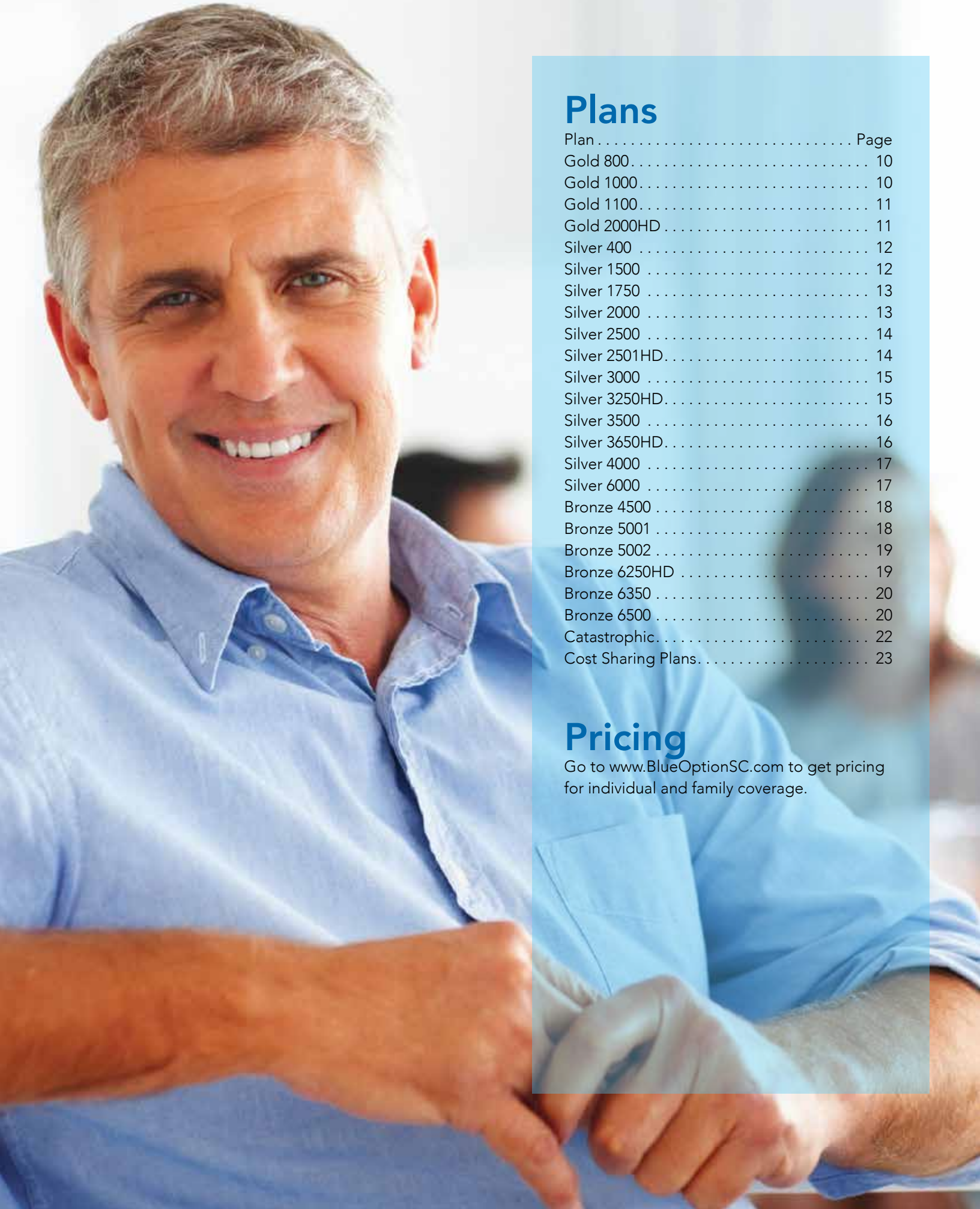
Cost Sharing Assistance — Under health care reform, this is extra help you can get to help you pay for your coinsurance, copayments or deductible in a qualified health plan. Whether or not you can get this help depends on your family's income level.

Deductible — The amount you must pay for covered services before your health plan starts to pay. For example, your plan has a $500 deductible. You must pay the first $500 of allowable charges for covered services before your plan starts to pay benefits. Your health plan may pay some benefits before you meet your deductible. For example, your plan may pay some preventive services at 100 percent even if you have not met your deductible.

Out-of-Pocket Costs — Your costs for health care that your health plan doesn't pay for. Depending on your plan, this may include your deductible, coinsurance and copayments for covered services.

Premium Tax Credit — A tax credit you can apply for to help you pay the monthly premium rate on a qualified health plan, starting in 2014. It is based on your household income and the federal poverty level. Also called a premium subsidy.

Referral — When your doctor sends you to a specialist or health care facility to get certain health care services. Some health plans require you to get this from your primary care physician.



Plans

Pricing

Go to www.BlueOptionSC.com to get pricing for individual and family coverage.

Benefit	Gold 800 (In Network Only)	Gold 1000 (In Network Only)
Deductible (single/family)	$800/$1,500	$1,000/$2,400
Coinsurance Maximum (single/family)	$3,500/$6,700	$6,350/$13,200
Primary Care Physician Services	$20 copayment per visit	$30 copayment per visit
Maternity Care (prenatal and postnatal)	$50 first visit	$60 copayment per visit
Specialist Visit	$50 copayment per visit	$60 copayment per visit
Inpatient Hospital Services	$300, then deductible, then 30%	Deductible, then 10%
Outpatient Hospital Services	Deductible, then 30%	Deductible, then 10%
Urgent Care	$50 copayment per visit	$50 copayment per visit
Emergency Room	$300, then deductible, then 30%	Deductible, then 10%
Ambulance	Deductible, then 30%	Deductible, then 10%
Mental Health and Substance Abuse (office services only)	Deductible, then 30%	Deductible, then 10%
Gynecologist Exam (one per benefit year)	$0	$0
Routine Screening Mammogram	$0	$0
Routine Screening Colonoscopy	$0	$0
Prescription Drugs	$10 generic/$35 preferred/deductible, then 30% coinsurance for non-preferred/$0 copayment for mandated preventive care medication/mail-order drugs covered at 2 times retail	$20 generic/$40 preferred/ 10% coinsurance for non-preferred/ $0 copayment for mandated preventive care medication/mail-order drugs covered at 2 times retail
Specialty Pharmaceuticals	$250, then deductible, then 30%	Deductible, then 10%
Durable Medical Equipment	Deductible, then 30%	Deductible, then 10%
Physical Therapy, Speech Therapy, Occupational Therapy and Habilitation	Deductible, then 30% 30 combined visits per benefit year	Deductible, then 10% 30 combined visits per benefit year

	Adult Routine Vision Care	Transplants	Preventive Dental Care
These benefits are applicable to all Gold plans (800, 1000, 1100, 2000HD)	$0 copayment for one routine eye exam or one exam for contact lenses per benefit period $45 copayment for one standard contact lens fitting per benefit period $0 copayment for one pair of eyewear from a designated selection every other benefit period *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. PEN Provider is an independent company that offers a vision network on behalf of BlueChoice HealthPlan*	A BlueChoice participating facility must provide services and we will treat covered transplants the same as any other medical condition.	*Any licensed dentist* One exam every six months – balance over $27 initial/$20 periodic One cleaning every six months – balance over $40 adult/$31 child

Benefit	Gold 1100 (In Network Only)	Gold 2000HD (In Network Only)
Deductible (single/family)	$1,100/$2,250	$2,000/$4,250
Coinsurance Maximum (single/family)	$3,000/$6,150	$2,000/$4,250
Primary Care Physician Services	$30 copayment per visit	Deductible
Maternity Care (prenatal and postnatal)	$60 first visit	Deductible
Specialist Visit	$60 copayment per visit	Deductible
Inpatient Hospital Services	$300, then deductible, then 20%	Deductible
Outpatient Hospital Services	Deductible, then 20%	Deductible
Urgent Care	$50 copayment per visit	Deductible
Emergency Room	$300, then deductible, then 20%	Deductible
Ambulance	Deductible, then 20%	Deductible
Mental Health and Substance Abuse (office services only)	Deductible, then 20%	Deductible
Gynecologist Exam (one per benefit year)	$0	$0
Routine Screening Mammogram	$0	$0
Routine Screening Colonoscopy	$0	$0
Prescription Drugs	$20 generic/$40 preferred/deductible, then 20% coinsurance for non-preferred/$0 copayment for mandated preventive care medication/mail-order drugs covered at 2 times retail	Deductible
Specialty Pharmaceuticals	$250, then deductible, then 20%	Deductible
Durable Medical Equipment	Deductible, then 20%	Deductible
Physical Therapy, Speech Therapy, Occupational Therapy and Habilitation	Deductible, then 20% 30 combined visits per benefit year	Deductible 30 combined visits per benefit year

	Pediatric Vision Care (Vision Service Plan (VSP) Network) *VSP is an independent company that offers a vision network on behalf of BlueChoice HealthPlan*
These benefits are applicable to all Gold plans (800, 1000, 1100, 2000HD)	$25 copayment for one comprehensive vision exam every calendar year $50 copayment for one pair of glasses (lenses and frames) per calendar year • Single vision, lined bifocal, lined trifocal or lenticular lenses covered in full (after materials copayment) • Frames from the Otis & Pieper Eyewear Collection are covered in full (after materials copayment) In lieu of eyeglasses, elective contact lens services and materials are covered with a minimum three-months' supply for any of the following modalities • Standard (one pair annually) • Monthly (six-month supply) • Bi-weekly (three-month supply) • Dailies (three-month supply) Necessary contact lenses are covered in full for members who have specific conditions for which contact lenses provide better visual correction

Benefit	Silver 400 (In Network Only)	Silver 1500 (In Network Only)
Deductible (single/family)	$400/$650	$1,500/$2,600
Coinsurance Maximum (single/family)	$6,350/$10,500	$6,350/$11,050
Primary Care Physician Services	Deductible, then 50%	$15 copayment per visit
Maternity Care (prenatal and postnatal)	Deductible, then 50%	Deductible, then 50%
Specialist Visit	Deductible, then 50%	Deductible, then 50%
Inpatient Hospital Services	Deductible, then 50%	Deductible, then 50%
Outpatient Hospital Services	Deductible, then 50%	Deductible, then 50%
Urgent Care	Deductible, then 50%	$50 copayment per visit
Emergency Room	Deductible, then 50%	$250 copayment per admission, then deductible, then 50%
Ambulance	Deductible, then 50%	Deductible, then 50%
Mental Health and Substance Abuse (office services only)	Deductible, then 50%	Deductible, then 50%
Gynecologist Exam (one per benefit year)	$0	$0
Routine Screening Mammogram	$0	$0
Routine Screening Colonoscopy	$0	$0
Prescription Drugs	Deductible, then 50%/$0 copayment for mandated preventive care medication/mail-order drugs covered at 2 times retail	$15 generic/50% coinsurance for non-generic/$0 copayment for mandated preventive care medication/mail-order drugs covered at 2 times retail
Specialty Pharmaceuticals	Deductible, then 50%	$250 copayment, then 50%
Durable Medical Equipment	Deductible, then 50%	Deductible, then 50%
Physical Therapy, Speech Therapy, Occupational Therapy and Habilitation	Deductible, then 50% 30 combined visits per benefit year	Deductible, then 50% 30 combined visits per benefit year

	Pediatric Vision Care (VSP Network)
These benefits are applicable to all Silver plans (400, 1500, 1750, 2000, 2500, 2501HD, 3000, 3250HD, 3500, 3650HD, 4000, 6000)	$25 copayment for one comprehensive vision exam every calendar year $50 copayment for one pair of glasses (lenses and frames) per calendar year • Single vision, lined bifocal, lined trifocal or lenticular lenses covered in full (after materials copayment) • Frames from the Otis & Pieper Eyewear Collection are covered in full (after materials copayment) In lieu of eyeglasses, elective contact lens services and materials are covered with a minimum three-months' supply for any of the following modalities • Standard (one pair annually) • Monthly (six-month supply) • Bi-weekly (three-month supply) • Dailies (three-month supply) Necessary contact lenses are covered in full for members who have specific conditions for which contact lenses provide better visual correction

Benefit	Silver 1750 (In Network Only)	Silver 2000 (In Network Only)
Deductible (single/family)	$1,750/$3,150	$2,000/$3,750
Coinsurance Maximum (single/family)	$6,350/$11,450	$4,500/$8,500
Primary Care Physician Services	$50 copayment per visit	$0 copayment
Maternity Care (prenatal and postnatal)	$100 first visit	Deductible, then 50%
Specialist Visit	$100 copayment per visit	Deductible, then 50%
Inpatient Hospital Services	$250 copayment per admission then deductible, then 30%	$300 copayment, then deductible, then 50%
Outpatient Hospital Services	$250 copayment, then deductible, then 30%	Deductible, then 50%
Urgent Care	$50 copayment per visit	$50 copayment per visit
Emergency Room	$250 copayment per admission then deductible, then 30%	$300 copayment, then deductible, then 50%
Ambulance	$250 copayment per admission then deductible, then 30%	Deductible, then 50%
Mental Health and Substance Abuse (office services only)	$250 copayment, then deductible, then 30%	Deductible, then 50%
Gynecologist Exam (one per benefit year)	$0	$0
Routine Screening Mammogram	$0	$0
Routine Screening Colonoscopy	$0	$0
Prescription Drugs	$10 generic/30% coinsurance for non-generic/$0 copayment for mandated preventive care medication/mail-order drugs covered at 2 times retail	$0 generic/deductible, then 50% for non-generic/$0 copayment for mandated preventive care medication/mail-order drugs covered at 2 times retail
Specialty Pharmaceuticals	30% coinsurance	Deductible, then 15%
Durable Medical Equipment	$250 copayment then deductible, then 30%	Deductible, then 50%
Physical Therapy, Speech Therapy, Occupational Therapy and Habilitation	$250 copayment then deductible, then 30% 30 combined visits per benefit year	Deductible, then 50% 30 combined visits per benefit year

	Adult Routine Vision Care	Transplants	Preventive Dental Care
These benefits are applicable to all Silver plans (400, 1500, 1750, 2000, 2500, 2501HD, 3000, 3250HD, 3500, 3650HD, 4000, 6000)	$0 copayment for one routine eye exam or one exam for contact lenses per benefit period $45 copayment for one standard contact lens fitting per benefit period $0 copayment for one pair of eyewear from a designated selection every other benefit period *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.*	A BlueChoice participating facility must provide services and we will treat covered transplants the same as any other medical condition.	*Any licensed dentist* One exam every six months – balance over $27 initial/$20 periodic One cleaning every six months – balance over $40 adult/$31 child

Benefit	Silver 2500 (In Network Only)	Silver 2501HD (In Network Only)
Deductible (single/family)	$2,500/$4,500	$2,500/$4,700
Coinsurance Maximum (single/family)	$6,350/$11,500	$5,650/$10,700
Primary Care Physician Services	$25 copayment per visit	Deductible, then 15%
Maternity Care (prenatal and postnatal)	$50 copayment per visit	Deductible, then 15%
Specialist Visit	$50 copayment per visit	Deductible, then 15%
Inpatient Hospital Services	$250 copayment per admission then deductible, then 30%	Deductible, then 15%
Outpatient Hospital Services	Deductible, then 30%	Deductible, then 15%
Urgent Care	$50 copayment per visit	Deductible, then 15%
Emergency Room	$250 copayment per admission then deductible, then 30%	Deductible, then 15%
Ambulance	$250 copayment per admission then deductible, then 30%	Deductible, then 15%
Mental Health and Substance Abuse (office services only)	$250 copayment, then deductible, then 30%	Deductible, then 15%
Gynecologist Exam (one per benefit year)	$0	$0
Routine Screening Mammogram	$0	$0
Routine Screening Colonoscopy	$0	$0
Prescription Drugs	$10 generic/30% coinsurance for non-generic/$0 copayment for mandated preventive care medication/mail-order drugs covered at 2 times retail	Deductible, then 15%/$0 copayment for mandated preventive care medication/mail-order drugs covered at 2 times retail
Specialty Pharmaceuticals	Deductible, then 30%	Deductible, then 15%
Durable Medical Equipment	$250 copayment then deductible, then 30%	Deductible, then 15%
Physical Therapy, Speech Therapy, Occupational Therapy and Habilitation	$250 copayment then deductible, then 30% 30 combined visits per benefit year	Deductible, then 15% 30 combined visits per benefit year

	Adult Routine Vision Care	Transplants	Preventive Dental Care
These benefits are applicable to all Silver plans (400, 1500, 1750, 2000, 2500, 2501HD, 3000, 3250HD, 3500, 3650HD, 4000, 6000)	$0 copayment for one routine eye exam or one exam for contact lenses per benefit period $45 copayment for one standard contact lens fitting per benefit period $0 copayment for one pair of eyewear from a designated selection every other benefit period *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.*	A BlueChoice participating facility must provide services and we will treat covered transplants the same as any other medical condition.	*Any licensed dentist* One exam every six months – balance over $27 initial/$20 periodic One cleaning every six months – balance over $40 adult/$31 child

Benefit	Silver 3000 (In Network Only)	Silver 3250HD (In Network Only)
Deductible (single/family)	$3,000/$5,400	$3,250/$6,350
Coinsurance Maximum (single/family)	$5,500/$9,950	$3,250/$6,350
Primary Care Physician Services	$20 copayment per visit	Deductible
Maternity Care (prenatal and postnatal)	$60 copayment per visit	Deductible
Specialist Visit	$60 copayment per visit	Deductible
Inpatient Hospital Services	$300 copayment, then deductible, then 50%	Deductible
Outpatient Hospital Services	Deductible, then 50%	Deductible
Urgent Care	$50 copayment per visit	Deductible
Emergency Room	$300 copayment, then deductible, then 50%	Deductible
Ambulance	Deductible, then 50%	Deductible
Mental Health and Substance Abuse (office services only)	Deductible, then 50%	Deductible
Gynecologist Exam (one per benefit year)	$0	$0
Routine Screening Mammogram	$0	$0
Routine Screening Colonoscopy	$0	$0
Prescription Drugs	$10 generic/$40 preferred/deductible, then 50% non-preferred/$0 copayment for mandated preventive care medication/mail-order drugs covered at 2 times retail	Deductible
Specialty Pharmaceuticals	$250 copayment, then deductible, then 50%	Deductible
Durable Medical Equipment	Deductible, then 50%	Deductible
Physical Therapy, Speech Therapy, Occupational Therapy and Habilitation	Deductible, then 50% 30 combined visits per benefit year	Deductible 30 combined visits per benefit year

	Pediatric Vision Care (VSP Network)
These benefits are applicable to all Silver plans (400, 1500, 1750, 2000, 2500, 2501HD, 3000, 3250HD, 3500, 3650HD, 4000, 6000)	$25 copayment for one comprehensive vision exam every calendar year $50 copayment for one pair of glasses (lenses and frames) per calendar year • Single vision, lined bifocal, lined trifocal or lenticular lenses covered in full (after materials copayment) • Frames from the Otis & Pieper Eyewear Collection are covered in full (after materials copayment) In lieu of eyeglasses, elective contact lens services and materials are covered with a minimum three-months' supply for any of the following modalities • Standard (one pair annually) • Monthly (six-month supply) • Bi-weekly (three-month supply) • Dailies (three-month supply) Necessary contact lenses are covered in full for members who have specific conditions for which contact lenses provide better visual correction

Benefit	Silver 3500 (In Network Only)	Silver 3650HD (In Network Only)
Deductible (single/family)	$3,500/$6,850	$3,650/$7,000
Coinsurance Maximum (single/family)	$4,500/$8,800	$3,650/$7,000
Primary Care Physician Services	$0 copayment per visit	Deductible
Maternity Care (prenatal and postnatal)	Deductible, then 30%	Deductible
Specialist Visit	Deductible, then 30%	Deductible
Inpatient Hospital Services	$300 copayment per admission then deductible, then 30%	Deductible
Outpatient Hospital Services	Deductible, then 30%	Deductible
Urgent Care	$50 copayment per visit	Deductible
Emergency Room	$300 copayment per admission then deductible, then 30%	Deductible
Ambulance	Deductible, then 30%	Deductible
Mental Health and Substance Abuse (office services only)	Deductible, then 30%	Deductible
Gynecologist Exam (one per benefit year)	$0	$0
Routine Screening Mammogram	$0	$0
Routine Screening Colonoscopy	$0	$0
Prescription Drugs	$0 generic/30% coinsurance for non-generic/$0 copayment for mandated preventive care medication/mail-order drugs covered at 2 times retail	Deductible/$0 copayment for mandated preventive care medication/ mail-order covered at 2 times retail
Specialty Pharmaceuticals	$250 copayment, then deductible, then 30%	Deductible
Durable Medical Equipment	Deductible, then 30%	Deductible
Physical Therapy, Speech Therapy, Occupational Therapy and Habilitation	Deductible, then 30% 30 combined visits per benefit year	Deductible 30 combined visits per benefit year

	Adult Routine Vision Care	Transplants	Preventive Dental Care
These benefits are applicable to all Silver plans (400, 1500, 1750, 2000, 2500, 2501HD, 3000, 3250HD, 3500, 3650HD, 4000, 6000)	$0 copayment for one routine eye exam or one exam for contact lenses per benefit period $45 copayment for one standard contact lens fitting per benefit period $0 copayment for one pair of eyewear from a designated selection every other benefit period *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.*	A BlueChoice participating facility must provide services and we will treat covered transplants the same as any other medical condition.	*Any licensed dentist* One exam every six months – balance over $27 initial/$20 periodic One cleaning every six months – balance over $40 adult/$31 child

Benefit	Silver 4000 (In Network Only)	Silver 6000 (In Network Only)
Deductible (single/family)	$4,000/$7,500	$6,000/$11,100
Coinsurance Maximum (single/family)	$5,000/$9,400	$6,350/$11,750
Primary Care Physician Services	$15 copayment per visit	$0 copayment
Maternity Care (prenatal and postnatal)	$40 first visit	$30 copayment per visit
Specialist Visit	$40 copayment per visit	$30 copayment
Inpatient Hospital Services	$300 copayment per admission, then deductible, then 30%	$300 copayment, then deductible, then 10%
Outpatient Hospital Services	Deductible, then 30%	Deductible, then 10%
Urgent Care	$50 copayment per visit	$50 copayment per visit
Emergency Room	$300 copayment per admission, then deductible, then 30%	$300 copayment, then deductible, then 10%
Ambulance	Deductible, then 30%	Deductible, then 10%
Mental Health and Substance Abuse (office services only)	Deductible, then 30%	Deductible, then 10%
Gynecologist Exam (one per benefit year)	$0	$0
Routine Screening Mammogram	$0	$0
Routine Screening Colonoscopy	$0	$0
Prescription Drugs	$15 generic/$50 copayment preferred/ deductible, then 30% non-preferred/ $0 copayment for mandated preventive care medication/mail-order drugs covered at 2 times retail	$10 generic/$30 preferred/$75 non-preferred/$0 copayment for mandated preventive care medication/mail-order drugs covered at 2 times retail
Specialty Pharmaceuticals	$250 copayment, then 30%	$250 copayment, then deductible, then 10%
Durable Medical Equipment	Deductible, then 30%	Deductible, then 10%
Physical Therapy, Speech Therapy, Occupational Therapy and Habilitation	Deductible, then 30% 30 combined visits per benefit year	Deductible, then 10% 30 combined visits per benefit year

	Pediatric Vision Care (VSP Network)
These benefits are applicable to all Silver plans (400, 1500, 1750, 2000, 2500, 2501HD, 3000, 3250HD, 3500, 3650HD, 4000, 6000)	$25 copayment for one comprehensive vision exam every calendar year $50 copayment for one pair of glasses (lenses and frames) per calendar year • Single vision, lined bifocal, lined trifocal or lenticular lenses covered in full (after materials copayment) • Frames from the Otis & Pieper Eyewear Collection are covered in full (after materials copayment) In lieu of eyeglasses, elective contact lens services and materials are covered with a minimum three-months' supply for any of the following modalities • Standard (one pair annually) • Monthly (six-month supply) • Bi-weekly (three-month supply) • Dailies (three-month supply) Necessary contact lenses are covered in full for members who have specific conditions for which contact lenses provide better visual correction

Benefit	Bronze 4500 (In Network Only)	Bronze 5001 (In Network Only)
Deductible (single/family)	$4,500/$8,000	$5,000/$8,650
Coinsurance Maximum (single/family)	$6,500/$11,550	$6,350/$11,000
Primary Care Physician Services	$30 copayment per visit	Deductible, then 50%
Maternity Care (prenatal and postnatal)	Deductible, then 50%	Deductible, then 50%
Specialist Visit	Deductible, then 50%	Deductible, then 50%
Inpatient Hospital Services	$300 copayment, then deductible, then 50%	Deductible, then 50%
Outpatient Hospital Services	Deductible, then 50%	Deductible, then 50%
Urgent Care	$50 copayment per visit	Deductible, then 50%
Emergency Room	$300 copayment, then deductible, then 50%	Deductible, then 50%
Ambulance	Deductible, then 50%	Deductible, then 50%
Mental Health and Substance Abuse (office services only)	Deductible, then 50%	Deductible, then 50%
Gynecologist Exam (one per benefit year)	$0	$0
Routine Screening Mammogram	$0	$0
Routine Screening Colonoscopy	$0	$0
Prescription Drugs	$30 generic/deductible, then 50% non-generic/$0 copayment for mandated preventive care medication/mail-order drugs covered at 2 times retail	Deductible, then 50%/$0 copayment for mandated preventive care medication/mail-order drugs covered at 2 times retail
Specialty Pharmaceuticals	$250 copayment, then deductible, then 50%	Deductible, then 50%
Durable Medical Equipment	Deductible, then 50%	Deductible, then 50%
Physical Therapy, Speech Therapy, Occupational Therapy and Habilitation	Deductible, then 50% 30 combined visits per benefit year	Deductible, then 50% 30 combined visits per benefit year

	Adult Routine Vision Care	Transplants	Preventive Dental Care
These benefits are applicable to all Bronze plans (4500, 5001, 5002, 6250HD, 6350, 6500)	$0 copayment for one routine eye exam or one exam for contact lenses per benefit period $45 copayment for one standard contact lens fitting per benefit period $0 copayment for one pair of eyewear from a designated selection every other benefit period *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.*	A BlueChoice participating facility must provide services and we will treat covered transplants the same as any other medical condition.	*Any licensed dentist* One exam every six months – balance over $27 initial/$20 periodic One cleaning every six months – balance over $40 adult/$31 child

Benefit	Bronze 5002 (In Network Only)	Bronze 6250HD (In Network Only)
Deductible (single/family)	$5,000/$8,900	$6,250/$10,850
Coinsurance Maximum (single/family)	$6,250/$11,100	$6,250/$10,850
Primary Care Physician Services	$50 copayment per visit	Deductible
Maternity Care (prenatal and postnatal)	$100 first visit	Deductible
Specialist Visit	$100 copayment per visit	Deductible
Inpatient Hospital Services	$1,000 copayment per admission then deductible, then 20%	Deductible
Outpatient Hospital Services	$1,000 copayment, then deductible, then 20%	Deductible
Urgent Care	$50 copayment per visit	Deductible
Emergency Room	$1,000 copayment per admission then deductible, then 20%	Deductible
Ambulance	$1,000 copayment per admission then deductible, then 20%	Deductible
Mental Health and Substance Abuse (office services only)	$1,000 copayment, then deductible, then 20%	Deductible
Gynecologist Exam (one per benefit year)	$0	$0
Routine Screening Mammogram	$0	$0
Routine Screening Colonoscopy	$0	$0
Prescription Drugs	$15 generic/20% coinsurance for non-generic/$0 copayment for mandated preventive care medication/mail-order drugs covered at 2 times retail	Deductible/$0 copayment for mandated preventive care medication/ mail-order covered at 2 times retail
Specialty Pharmaceuticals	Deductible, then 20%	Deductible
Durable Medical Equipment	$1,000 copayment then deductible, then 20%	Deductible
Physical Therapy, Speech Therapy, Occupational Therapy and Habilitation	$1,000 copayment then deductible, then 20% 30 combined visits per benefit year	Deductible 30 combined visits per benefit year

	Pediatric Vision Care (VSP Network)
These benefits are applicable to all Bronze plans (4500, 5001, 5002, 6250HD, 6350, 6500)	$25 copayment for one comprehensive vision exam every calendar year $50 copayment for one pair of glasses (lenses and frames) per calendar year • Single vision, lined bifocal, lined trifocal or lenticular lenses covered in full (after materials copayment) • Frames from the Otis & Pieper Eyewear Collection are covered in full (after materials copayment) In lieu of eyeglasses, elective contact lens services and materials are covered with a minimum three-months' supply for any of the following modalities • Standard (one pair annually) • Monthly (six-month supply) • Bi-weekly (three-month supply) • Dailies (three-month supply) Necessary contact lenses are covered in full for members who have specific conditions for which contact lenses provide better visual correction

Benefit	Bronze 6350 (In Network Only)	Bronze 6500 (In Network Only)
Deductible (single/family)	$6,350/$10,950	$6,500/$11,100
Coinsurance Maximum (single/family)	$6,350/$10,950	$6,500/$11,100
Primary Care Physician Services	$50 copayment per visit	$0 copayment per visit
Maternity Care (prenatal and postnatal)	$100 first visit	Deductible
Specialist Visit	$100 copayment per visit	Deductible
Inpatient Hospital Services	Deductible	$300 copayment, then deductible
Outpatient Hospital Services	Deductible	Deductible
Urgent Care	$50 copayment per visit	$50 copayment per visit
Emergency Room	Deductible	$300 copayment per admission then deductible
Ambulance	Deductible	Deductible
Mental Health and Substance Abuse (office services only)	Deductible	Deductible
Gynecologist Exam (one per benefit year)	$0	$0
Routine Screening Mammogram	$0	$0
Routine Screening Colonoscopy	$0	$0
Prescription Drugs	Deductible/$0 copayment for mandated preventive care medication/ mail-order covered at 2 times retail	$25 generic/deductible for non-generic/$0 copayment for mandated preventive care medication/mail-order drugs covered at 2 times retail
Specialty Pharmaceuticals	Deductible	Deductible
Durable Medical Equipment	Deductible	Deductible
Physical Therapy, Speech Therapy, Occupational Therapy and Habilitation	Deductible 30 Combined visits per benefit year	Deductible 30 Combined visits per benefit year

<table>
<tr><th></th><th>Adult Routine Vision Care</th><th>Transplants</th><th>Preventive Dental Care</th></tr>
<tr><td rowspan="2">These benefits are applicable to all Bronze plans (4500, 5001, 5002, 6250HD, 6350, 6500)</td><td>$0 copayment for one routine eye exam or one exam for contact lenses per benefit period
$45 copayment for one standard contact lens fitting per benefit period
$0 copayment for one pair of eyewear from a designated selection every other benefit period
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.</td><td>A BlueChoice participating facility must provide services and we will treat covered transplants the same as any other medical condition.</td><td>Any licensed dentist
One exam every six months – balance over $27 initial/$20 periodic
One cleaning every six months – balance over $40 adult/$31 child</td></tr>
<tr><td colspan="3">Pediatric Vision Care (VSP Network)
$25 copayment for one comprehensive vision exam every calendar year
$50 copayment for one pair of glasses (lenses and frames) per calendar year
• Single vision, lined bifocal, lined trifocal or lenticular lenses covered in full (after materials copayment)
• Frames from the Otis & Pieper Eyewear Collection are covered in full (after materials copayment)
In lieu of eyeglasses, elective contact lens services and materials are covered with a minimum three-months' supply for any of the following modalities
• Standard (one pair annually) • Monthly (six-month supply)
• Bi-weekly (three-month supply) • Dailies (three-month supply)
Necessary contact lenses are covered in full for members who have specific conditions for which contact lenses provide better visual correction</td></tr>
</table>

Benefit	Catastrophic (In Network Only)
Deductible	$6,600
Coinsurance Maximum	$6,600
Primary Care Physician Services	$25 copayment per visit for first 3 visits; visits 4 and up, deductible
Maternity Care (prenatal and postnatal)	Deductible
Specialist Visit	Deductible
Inpatient Hospital Services	Deductible
Outpatient Hospital Services	Deductible
Urgent Care	Deductible
Emergency Room	Deductible
Ambulance	Deductible
Mental Health and Substance Abuse (office services only)	Deductible
Gynecologist Exam (one per benefit year)	$0
Routine Screening Mammogram	$0
Routine Screening Colonoscopy	$0
Prescription Drugs	Deductible/$0 copayment for mandated preventive care medication/mail-order drugs covered at 2 times retail
Specialty Pharmaceuticals	Deductible
Adult Routine Vision Care	$0 copayment for a routine eye exam or exam for contact lenses per benefit period $45 copayment for one standard contact lens fitting per benefit period $0 copayment for one pair of eyewear from a designated selection every other benefit period *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.*
Pediatric Vision Care (VSP Network)	$25 copayment for one comprehensive vision exam every calendar year $50 copayment for one pair of glasses (lenses and frames) per calendar year • Single vision, lined bifocal, lined trifocal or lenticular lenses covered in full (after materials copay) In lieu of eyeglasses, elective contact lens services and materials are covered with a minimum three-months' supply for any of the following modalities • Standard (one pair annually) • Monthly (six-month supply) • Bi-weekly (three-month supply) • Dailies (three-month supply) Necessary contact lenses are covered in full for members who have specific conditions for which contact lenses provide better visual correction
Preventive Dental Care	*Any licensed dentist* One exam every six months – balance over $27 initial/$20 periodic One cleaning every six months – balance over $40 adult/$31 child
Durable Medical Equipment	Deductible
Physical Therapy, Speech Therapy, Occupational Therapy and Habilitation	Deductible 30 Combined visits per benefit year
Transplants	A BlueChoice participating facility must provide services and we will treat covered transplants the same as any other medical condition.

Cost Sharing Plans

See FPL chart on page 23 to determine your cost sharing level.

Plan Name	Base Plan	Cost Share 1 200-250% FPL	Cost Share 2 150-200% FPL	Cost Share 3 100-150% FPL
Silver 400				
Coinsurance	50%	50%	25%	15%
Deductible (single/family)	$400/$650	$100/$150	$75/$100	$75/$100
Out-of-pocket limit (single/family)	$6,350/$10,500	$5,100/$8,300	$2,250/$3,850	$850/$1,650
Silver 1500				
Coinsurance	50%	50%	20%	10%
Deductible (single/family)	$1,500/$2,600	$750/$1,300	$250/$450	$100/$200
Out-of-pocket limit (single/family)	$6,350/$11,050	$5,200/$9,050	$2,250/$4,200	$750/$1,500
Silver 1750				
Coinsurance	30%	20%	10%	10%
Deductible (single/family)	$1,750/$3,150	$1,500/$2,850	$250/$450	$100/$200
Out-of-pocket limit (single/family)	$6,350/$11,450	$5,200/$9,850	$1,750/$3,400	$450/$1,000
Silver 2000				
Coinsurance	50%	50%	50%	50%
Deductible (single/family)	$2,000/$3,750	$1,750/$3,350	$500/$1,050	$250/$600
Out-of-pocket limit (single/family)	$4,500/$8,500	$4,000/$7,700	$1,500/$3,250	$600/$1,450
Silver 2500				
Coinsurance	30%	30%	15%	10%
Deductible (single/family)	$2,500/$4,500	$1,500/$2,750	$250/$450	$250/$600
Out-of-pocket limit (single/family)	$6,350/$11,500	$5,200/$9,600	$2,250/$4,150	$500/$1,200
Silver 2501HD				
Coinsurance	15%	15%	10%	10%
Deductible (single/family)	$2,500/$4,700	$1,850/$3,600	$750/$1,600	$250/$550
Out-of-pocket limit (single/family)	$5,650/$10,700	$5,150/$10,050	$1,500/$3,250	$675/$1,500
Silver 3000				
Coinsurance	50%	50%	50%	10%
Deductible (single/family)	$3,000/$5,400	$3,000/$5,400	$500/$1,000	$300/$700
Out-of-pocket limit (single/family)	$5,500/$9,950	$5,200/$9,450	$1,750/$3,650	$750/$1,750
Silver 3250HD				
Coinsurance	100%	100%	100%	100%
Deductible (single/family)	$3,250/$6,350	$2,900/$5,800	$1,150/$2,600	$400/$1,000
Out-of-pocket limit (single/family)	$3,250/$6,350	$2,900/$5,800	$1,150/$2,600	$400/$1,000
Silver 3500				
Coinsurance	30%	30%	30%	10%
Deductible (single/family)	$3,500/$6,850	$3,500/$6,850	$1,000/$2,300	$250/$550
Out-of-pocket limit (single/family)	$4,500/$8,800	$3,750/$7,450	$1,500/$3,450	$750/$1,750
Silver 3650HD				
Coinsurance	100%	100%	100%	100%
Deductible (single/family)	$3,650/$7,000	$2,900/$5,800	$1,150/$2,600	$400/$1,000
Out-of-pocket limit (single/family)	$3,650/$7,000	$2,900/$5,800	$1,150/$2,600	$400/$1,000
Silver 4000				
Coinsurance	30%	30%	30%	30%
Deductible (single/family)	$4,000/$7,500	$4,000/$7,500	$1,000/$2,200	$300/$700
Out-of-pocket limit (single/family)	$5,000/$9,400	$5,000/$9,400	$1,750/$3,850	$600/$1,450
Silver 6000				
Coinsurance	10%	10%	10%	10%
Deductible (single/family)	$6,000/$11,100	$5,000/$9,650	$1,000/$2,250	$300/$700
Out-of-pocket limit (single/family)	$6,350/$11,750	$5,200/$10,050	$2,250/$4,500	$600/$1,450

Federal Poverty Level (FPL) Guidelines

The Federally Facilitated Marketplace will use these household size and income guidelines to determine eligibility for subsidies and cost sharing levels for 2015. Subsidies are available for any plan (except Catastrophic) for those with a household income under 400 percent FPL. Cost sharing is only available with Silver plans and for those with a household income below 250 percent FPL.

See page 23 for the coinsurance percentage, deductible and out-of-pocket limits for each Blue Option Silver plan.

Household Size	100%	133%	150%	200%	250%	300%	400%
1	$11,670	$15,521	$17,505	$23,340	$29,175	$35,010	$46,680
2	$15,730	$20,921	$23,595	$31,460	$39,325	$47,190	$62,920
3	$19,790	$26,321	$29,685	$39,580	$49,475	$59,370	$79,160
4	$23,850	$31,721	$35,775	$47,700	$59,625	$71,550	$95,400
5	$27,910	$37,120	$41,865	$55,820	$69,775	$83,730	$111,640
6	$31,970	$42,520	$47,955	$63,940	$79,925	$95,910	$127,880
7	$36,030	$47,920	$54,045	$72,060	$90,075	$108,090	$144,120
8	$40,090	$53,320	$60,135	$80,180	$100,225	$120,270	$160,360

Value-Added Benefits of Blue Option Membership

24/7 Nurseline

- Nurse answers the phone and assists member
- Medical doctor available via phone or video ($35 copayment)

Life Management Services

- Financial or legal assistance
- Parenting/child care assistance

Personal Health Assessment

- Capture key health information to keep you healthy and identify health issues to address

Be In Control of Your Health Care!

My Health Toolkit®

Our online tools and resources can help you manage your health.

- Access claims and health coverage information
- Rate your visit
- Contribution calculators
- Doctor and hospital finder
- Prescription drugs
- Personal Health Assessment
- Personal Health Record
- Health library

Fitness & Wellness

Natural Blue℠

- Enjoy Natural Blue discounts at these alternative health specialists:
  - Chiropractors
  - Massage therapists
  - Fitness centers and more!
- Supplements and more
- Access to the ChooseHealthy™ online store discount program.

Jenny Craig Weight Loss

FREE 30-Day Program or 30 percent off membership

My Gym Children's Fitness Center

Special discount just for our members.

WalkingWorks®

Increase your physical activity and improve your health through walking.

Discount Programs

QualSight Lasik & TruHearing Digital Hearing Aids

Discounts on Lasik surgery and hearing aids

Bosley Hair Restoration

Discount on hair transplantation procedure.

Cosmetic Surgery

Substantial savings on a variety of cosmetic procedures.

Companion Global Healthcare

Save on some medical procedures at accredited hospitals overseas.

Blue365®

Discounts on a variety of programs from companies like Reebok, Sprint, Nutrisystem, Seniorlink and Fairmont Hotels and Resorts.

Because It Matters How You're Treated

BlueChoice HealthPlan's goal is to help keep you healthy. We look forward to helping you decide which Blue Option plan is best for you and your family members.

For more information on Blue Option plans, you can:

1. Visit www.BlueOptionSC.com, our private exchange where you can get product information, pricing and instructions on how to check if you qualify for a subsidy or apply for coverage.
2. Call our Blue Option Call Center at 855-433-2132. Assistance is available Monday–Friday, 8:30 a.m.–5 p.m.
3. Contact a local insurance agent.

Because It Matters How You're Treated

BlueChoice® HealthPlan
South Carolina

16248-9-2014