# Schedule of Benefits

## First Choice Next Silver Deluxe

Benefit period: From 01/01/2025 through 12/31/2025 Calendar Year.

**This Schedule of Benefits outlines services that may be covered under your health benefit plan. Select Health of South Carolina, Inc. is a Health Maintenance Organization (HMO). Please refer to the Evidence of Coverage (EOC) document for more details on covered health services and important limitations. Your EOC also describes preventive services covered with no cost sharing. As a member, you are responsible for the deductible, copayments, and coinsurance for eligible services. For services that require prior authorization, network providers must obtain authorization from us prior to providing a service or supply to a member. You should confirm with your provider that they have received prior authorization for a covered service prior to your treatment.**

Insured's Name:_____

Policy Number:_____

# About your Schedule of Benefits

This Schedule of Benefits outlines services that may be covered under your health benefit plan. Please refer to the Evidence of Coverage (EOC) document for more details on covered health services and important limitations. Your EOC also describes preventive services covered with no cost sharing. As a member, you are responsible for the deductible, copayments, and coinsurance for eligible services.

## Coinsurance

A percentage of the allowed amount you are required to pay for covered health services and prescription drugs, for example 20%. A copayment is not a coinsurance.

## Copayment

A specific dollar amount you may be required to pay as your share of the allowed amount for covered health services or prescription drugs you receive. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug. A copayment is not a coinsurance.

## Deductible

The amount you must pay for covered health services or prescription drugs each year before the health benefit plan begins to pay.

## Limitations and Exclusions

Some benefit limitations and exclusions are outlined on p. 3-7 below. Please review your EOC and other policy documents. These give a full description of services and items that are limited or not covered by your health benefit plan.

## Out-of-Pocket Maximum

The most that you pay out-of-pocket during the calendar year for in-network covered health services. It includes deductibles and any cost sharing amounts the member has paid. Amounts you pay for premiums do not count toward the out-of-pocket maximum amount.

## Quantity Limits

A tool to limit the use of selected drugs for quality, safety, or utilization reasons. Drugs may be limited by the amount that we cover per prescription or for a defined period of time.

## Prior Authorization

Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other in-network provider gets prior authorization from your health benefit plan.

**Note:**

First Choice Next plans do not offer embedded pediatric dental coverage as there are stand-alone pediatric dental plans available in the exchange for purchase. First Choice Next will inform consumers of the availability of stand-alone pediatric dental plans during the plan selection and enrollment process.

# Your Deductible and Out-of-Pocket Maximum

This Benefit Overview describes your coverage and Cost Sharing Amounts, including Deductible and Out-of-Pocket Maximum, under this plan.

| General Cost Share & Features | In Network | Out of Network |
|---|---|---|
| **Deductible:**<br>- Per Calendar Year<br>- Medical and Drug Combined<br>- Some services do not apply to the deductible, as indicated below. | $4,300/Individual<br>$8,600/Family | Not Covered |
| **Out-of-Pocket Maximum:**<br>- Per Calendar Year<br>- Medical and Drug Combined | $7,350/Individual<br>$14,700/Family | Not Covered |

If you are the subscriber, and the only member covered under your health benefit plan, the individual out-of-pocket maximum amount applies. If you have other family members on your plan, the family out-of-pocket maximum amount applies. The plan has an embedded individual out-of-pocket maximum within the family out-of-pocket maximum. No one member can contribute more than their individual out-of-pocket maximum amount to the family out-of-pocket maximum. Copayment or coinsurance amounts a member pays for services shown as covered without an out-of-pocket maximum will not count toward meeting the individual or family out-of-pocket maximum.

# Benefit Details

The following table provides basic information about your benefits under this plan.

| Benefit | In Network | Out of Network |
|---|---|---|
| **Primary & Specialist Office Visits** | | |
| Other Practitioner Office Visit (Nurse, Physician Assistant) | $15 Copay per visit | Not Covered |
| Primary Care Visit to Treat an Injury or Illness | $15 Copay per visit | Not Covered |
| Routine Foot Care | $30 Copay per visit | Not Covered |
| Specialist Visit | $30 Copay per visit | Not Covered |
| Virtual Care 24/7<br>*Virtual Care visits offered through First Choice Next Virtual Care 24/7 are covered at No Charge; your deductible does not apply. Otherwise, virtual care visits are subject to the same cost sharing responsibilities as office visits.* | No Charge | Not Covered |
| **Preventive Care** | | |
| Nutritional Counseling | No Charge | Not Covered |
| Preventive Care/Screening/Immunization | No Charge | Not Covered |
| Well Baby Visits and Care | No Charge | Not Covered |

| Benefit | In Network | Out of Network |
|---|---|---|
| **Therapy** | | |
| Chiropractic Care† | Deductible, then 30% Coinsurance | Not Covered |
| Habilitation Services† | Deductible, then 30% Coinsurance | Not Covered |
| Outpatient Rehabilitation Services† | Deductible, then 30% Coinsurance | Not Covered |
| Rehabilitative Occupational and Rehabilitative Physical Therapy†<br>*30 visits per benefit period* | Deductible, then 30% Coinsurance | Not Covered |
| Rehabilitative Speech Therapy†<br>*30 visits per benefit period* | Deductible, then 30% Coinsurance | Not Covered |
| Infusion Therapy† | Deductible, then 30% Coinsurance | Not Covered |
| Chemotherapy† | Deductible, then 30% Coinsurance | Not Covered |
| Radiation | Deductible, then 30% Coinsurance | Not Covered |
| **Diagnostic & Imaging** | | |
| Imaging (CT/PET Scans, MRIs)† | Deductible, then 30% Coinsurance | Not Covered |
| Laboratory Outpatient and Professional Services† | Deductible, then 30% Coinsurance | Not Covered |
| X-rays and Diagnostic Imaging | Deductible, then 30% Coinsurance | Not Covered |
| **Outpatient Care** | | |
| Mental/Behavioral Health Outpatient Services† | $15 Copay per visit | Not Covered |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)† | Deductible, then 30% Coinsurance | Not Covered |
| Outpatient Surgery Physician/Surgical Services† | Deductible, then 30% Coinsurance | Not Covered |
| Substance Abuse Disorder Outpatient Services† | $15 Copay per visit | Not Covered |
| **Inpatient Care** | | |
| Delivery and All Inpatient Services for Maternity Care† | Deductible, then 30% Coinsurance | Not Covered |
| Inpatient Hospital Services (e.g., Hospital Stay)† | Deductible, then 30% Coinsurance | Not Covered |
| Inpatient Physician and Surgical Services† | Deductible, then 30% Coinsurance | Not Covered |
| Mental/Behavioral Health Inpatient Services† | Deductible, then 30% Coinsurance | Not Covered |
| Skilled Nursing Facility†<br>*60 days per benefit period* | Deductible, then 30% Coinsurance | Not Covered |
| Substance Abuse Disorder Inpatient Services† | Deductible, then 30% Coinsurance | Not Covered |
| **Hospice Care** | | |
| Hospice Services†<br>*6 months per episode* | Deductible, then No Charge | Not Covered |

| Benefit | In Network | Out of Network |
|---|---|---|
| **Home Health Care, Nursing Home Care, and Private Duty Nursing** | | |
| Home Health Care Services†<br>*60 visits per benefit period* | Deductible, then 30% Coinsurance | Not Covered |
| Long-Term/Custodial Nursing Home Care | Not Covered | Not Covered |
| Private-Duty Nursing | Not Covered | Not Covered |
| **Urgent Care** | | |
| Urgent Care Centers or Facilities | $45 Copay per visit | |
| **Emergency Care/Ambulance** | | |
| Emergency Room Services | Deductible, then 30% Coinsurance | |
| Emergency Transportation/Ambulance | Deductible, then 30% Coinsurance | |
| **Durable Medical Equipment and Devices** | | |
| Durable Medical Equipment† | Deductible, then 50% Coinsurance | Not Covered |
| Prosthetic Devices† | Deductible, then 50% Coinsurance | Not Covered |
| **Dental Care** | | |
| Accidental Dental† | Deductible, then 30% Coinsurance | Not Covered |
| Basic Dental Care – Child | Not Covered | Not Covered |
| Basic Dental Care – Adult | Not Covered | Not Covered |
| Dental Check-Up for Children | Not Covered | Not Covered |
| Major Dental Care – Child | Not Covered | Not Covered |
| Major Dental Care – Adult | Not Covered | Not Covered |
| Orthodontia – Child | Not Covered | Not Covered |
| Orthodontia – Adult | Not Covered | Not Covered |
| Routine Dental Services (Adult) | Not Covered | Not Covered |
| **Pediatric Vision Services**<br>**Covered through the last day of the month in which a child turns 19** | | |
| Contact Lenses for Children<br>*1 pair of children's eye glasses (with standard frames and lenses) or contact lenses per benefit period* | Deductible, then 30% Coinsurance | Not Covered |
| Eye Glasses for Children<br>*1 pair of children's eye glasses (with standard frames and lenses) or contact lenses per benefit period* | Deductible, then 30% Coinsurance | Not Covered |
| Low Vision Exams and Aids for Children†<br>*1 exam per 5 years* | Deductible, then 30% Coinsurance | Not Covered |
| Routine Eye Exam for Children<br>*1 exam per benefit period* | Deductible, then 30% Coinsurance | Not Covered |

| Benefit | In Network | Out of Network |
|---|---|---|
| **Additional Services** | | |
| Abortion for Which Public Funding is Prohibited | Not Covered | Not Covered |
| Acupuncture | Not Covered | Not Covered |
| Allergy Testing | $30 Copay per visit | Not Covered |
| Bariatric Surgery | Not Covered | Not Covered |
| Cardiac Rehabilitation†<br>*30 visits per benefit period* | Deductible, then 30% Coinsurance | Not Covered |
| Congenital Anomaly, including Cleft Lip/Palate† | Deductible, then 30% Coinsurance | Not Covered |
| Cosmetic Surgery | Not Covered | Not Covered |
| Diabetes Education | No Charge | Not Covered |
| Diabetes Supplies† | Deductible, then 30% Coinsurance | Not Covered |
| Dialysis | Deductible, then 30% Coinsurance | Not Covered |
| Hearing Aids | Not Covered | Not Covered |
| Infertility Treatment | Not Covered | Not Covered |
| Mastectomy† | Deductible, then 30% Coinsurance | Not Covered |
| Prenatal and Postnatal Care | No Charge | Not Covered |
| Pulmonary Rehabilitation†<br>*36 treatments per benefit period* | Deductible, then 30% Coinsurance | Not Covered |
| Reconstructive Surgery† | Deductible, then 30% Coinsurance | Not Covered |
| Routine Eye Exam (Adult) | Not Covered | Not Covered |
| Transplant† | Deductible, then 30% Coinsurance | Not Covered |
| Treatment for Temporomandibular Joint Disorders | Not Covered | Not Covered |
| Weight Loss Programs | Not Covered | Not Covered |

† Prior authorization may be required

# Prescription Drugs

**Prescription Deductible and Out-of-Pocket Maximum (OOPM)**

| Prescription Cost Share & Features | In Network | Out of Network |
|---|---|---|
| Deductible<br>(Integrated with Medical Deductible) | $4,300/Individual<br>$8,600/Family | Not Covered |
| Out of Pocket Maximum<br>(Integrated with Medical Out of Pocket Maximum) | $7,350/Individual<br>$14,700/Family | Not Covered |

| Retail Pharmacy (per 30 day supply) | | |
|---|---|---|
| **Tier** | **In Network** | **Out of Network** |
| Generic Drugs | $15 Copay per prescription | Not Covered |
| Preferred Brand Drugs | $100 Copay per prescription | Not Covered |
| Non-Preferred Brand Drugs | Deductible, then 40% Coinsurance | Not Covered |
| Specialty Drugs | Deductible, then 40% Coinsurance | Not Covered |

Prescription Drug Notes:

1. Covers up to a 30-day supply for retail prescriptions; 31–90 day supply for mail order prescriptions.
2. Cost share shown is per retail prescription per 30-day supply. Mail order cost share is 2.5 times retail cost.
3. Prior authorization / step therapy may be required.
4. Certain off-label uses of cancer drugs will be covered in accordance with state law.