Schedule of Benefits

First Choice Next Silver Essential - $850 Deductible

Benefit period: From 01/01/2027 through 12/31/2027 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

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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: - Per Calendar Year - Medical and Drug Combined - Some services do not apply to the deductible, as indicated below.	$850/Individual $1,700/Family	Not Covered
Out-of-Pocket Maximum: - Per Calendar Year - Medical and Drug Combined	$4,000/Individual $8,000/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		
Primary Care Visit to Treat an Injury or Illness	From 1 to 2 Visit - No Charge Visit 3 and after - $20 Copayment per visit	Not Covered
Specialist Visit	$40 Copay per visit	Not Covered
Other Practitioner Office Visit (Nurse, Physician Assistant)	$20 Copay per visit	Not Covered
Routine Foot Care	$40 Copay per visit	Not Covered
Virtual Care 24/7 *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
Therapy		
Chiropractic Care† *Up to 30 visits per benefit period*	$40 Copay per visit	Not Covered

Benefit	In Network	Out of Network
Habilitation Services†	Deductible, then 15% Coinsurance	Not Covered
Outpatient Rehabilitation Services†	Deductible, then 15% Coinsurance	Not Covered
Rehabilitative Occupational and Rehabilitative Physical Therapy† *30 visits per benefit period*	Deductible, then 15% Coinsurance	Not Covered
Rehabilitative Speech Therapy† *30 visits per benefit period*	Deductible, then 15% Coinsurance	Not Covered
Infusion Therapy†	Deductible, then 15% Coinsurance	Not Covered
Chemotherapy†	Deductible, then 15% Coinsurance	Not Covered
Radiation	Deductible, then 15% Coinsurance	Not Covered
Diagnostic & Imaging		
Imaging (CT/PET Scans, MRIs)†	Deductible, then 15% Coinsurance	Not Covered
Laboratory Outpatient and Professional Services†	Deductible, then 15% Coinsurance	Not Covered
X-rays and Diagnostic Imaging	Deductible, then 15% Coinsurance	Not Covered
Outpatient Care		
Mental/Behavioral Health Office Visits	From 1 to 2 Visit - No Charge Visit 3 and after - $20 Copayment per visit	Not Covered
Mental/Behavioral Health Outpatient Services†	Deductible, then 15% Coinsurance	Not Covered
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)†	Deductible, then 15% Coinsurance	Not Covered
Outpatient Surgery Physician/Surgical Services†	Deductible, then 15% Coinsurance	Not Covered
Substance Abuse Disorder Office Visits	From 1 to 2 Visit - No Charge Visit 3 and after - $20 Copayment per visit	Not Covered
Substance Abuse Disorder Outpatient Services†	Deductible, then 15% Coinsurance	Not Covered
Inpatient Care		
Childbirth/Delivery Facility Services†	Deductible, then 15% Coinsurance	Not Covered
Coronary Artery Bypass Graft†	Deductible, then 15% Coinsurance	Not Covered
Inpatient Hospital Services (e.g., Hospital Stay)†	Deductible, then 15% Coinsurance	Not Covered
Inpatient Physician and Surgical Services†	Deductible, then 15% Coinsurance	Not Covered
Mental/Behavioral Health Inpatient Services†	Deductible, then 15% Coinsurance	Not Covered
Skilled Nursing Facility† *60 days per benefit period*	Deductible, then 15% Coinsurance	Not Covered
Substance Abuse Disorder Inpatient Services†	Deductible, then 15% Coinsurance	Not Covered

Benefit	In Network	Out of Network
Hospice Care		
Hospice Services† *6 months per episode*	Deductible, then No Charge	Not Covered
Home Health Care, Nursing Home Care, and Private Duty Nursing		
Home Health Care Services† *60 visits per benefit period*	Deductible, then 15% 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	$60 Copay per visit	
Emergency Care/Ambulance		
Emergency Room Services	Deductible, then 15% Coinsurance	
Emergency Transportation/Ambulance	Deductible, then 15% 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 15% 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 **Covered through the last day of the month in which a child turns 19**		
Contact Lenses for Children *1 pair of children's eye glasses (with standard frames and lenses) or contact lenses per benefit period*	No Charge	Not Covered
Eye Glasses for Children *1 pair of children's eye glasses (with standard frames and lenses) or contact lenses per benefit period*	No Charge	Not Covered
Low Vision Exams and Aids for Children† *1 exam per 5 years*	Deductible, then 15% Coinsurance	Not Covered

Benefit	In Network	Out of Network
Routine Eye Exam for Children *1 exam per benefit period*	No Charge	Not Covered
Additional Services		
Abortion for Which Public Funding is Prohibited	Not Covered	Not Covered
Acupuncture	Not Covered	Not Covered
Allergy Testing	$40 Copay per visit	Not Covered
Bariatric Surgery	Not Covered	Not Covered
Cardiac Rehabilitation† *30 visits per benefit period*	Deductible, then 15% Coinsurance	Not Covered
Congenital Anomaly, including Cleft Lip/Palate†	Deductible, then 15% Coinsurance	Not Covered
Cosmetic Surgery	Not Covered	Not Covered
Diabetes Education	No Charge	Not Covered
Diabetes Supplies†	Deductible, then 15% Coinsurance	Not Covered
Dialysis	Deductible, then 15% Coinsurance	Not Covered
Doula *1500 dollars per pregnancy*	$40 Copay per visit	Not Covered
Hearing Aids	Not Covered	Not Covered
Infertility Treatment	Not Covered	Not Covered
Mastectomy†	Deductible, then 15% Coinsurance	Not Covered
Routine Prenatal and Postnatal Care	No Charge	Not Covered
Pulmonary Rehabilitation† *36 treatments per benefit period*	Deductible, then 15% Coinsurance	Not Covered
Reconstructive Surgery†	Deductible, then 15% Coinsurance	Not Covered
Routine Eye Exam (Adult)	Not Covered	Not Covered
Transplant†	Deductible, then 15% 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 (Integrated with Medical Deductible)	$850/Individual $1,700/Family	Not Covered
Out of Pocket Maximum (Integrated with Medical Out of Pocket Maximum)	$4,000/Individual $8,000/Family	Not Covered

Retail Pharmacy (per 30 day supply)		
Tier	**In Network**	**Out of Network**
Preferred Generic Drugs (Tier 1a)	$5 Copay per prescription	Not Covered
Non-Preferred Generic Drugs (Tier 1b)	$25 Copay per prescription	Not Covered
Preferred Brand Drugs (Tier 2)	$60 Copay per prescription	Not Covered
Non-Preferred Brand and Non-Preferred (High Cost) Generic Drugs (Tier 3)	Deductible, then 35% Coinsurance	Not Covered
Specialty Drugs (Tier 4a)	Deductible, then 40% Coinsurance	Not Covered
Non-Preferred Specialty Drugs (Tier 4b)	Deductible, then 50% 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.

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, phone: **1-800-368-1019 (TTY 1-800-537-7697)**. Complaint forms are available at **https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf**.

We speak your language

We provide free language services and information to people whose primary language is not English. To talk to an interpreter, call the Member Services number on the back of your card.

Ofrecemos servicios lingüísticos e información sin cargo a las personas cuya lengua materna no es el inglés. Para hablar con un intérprete, llame al número de Servicios al Miembro que figura en el dorso de su tarjeta.

我们为母语非英语的人士提供免费的语言服务及信息。如需与翻译交谈，请拨打您的会员卡背面的会员服务部电话。

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Wir bieten Menschen, deren Muttersprache nicht Englisch ist, kostenlose Sprachdienste und Informationen an. Wenn Sie mit einem Dolmetscher oder einer Dolmetscherin sprechen möchten, rufen Sie bitte die Nummer des Mitgliederservice auf der Rückseite Ihrer Karte an.

Nous fournissons gratuitement des services linguistiques et des informations à ceux dont la langue principale n'est pas l'anglais. Pour communiquer avec un interprète, appelez l'équipe service aux adhérents au numéro indiqué au dos de votre carte.

Prestamos informações e serviços linguísticos gratuitos a pessoas cujo idioma principal não é o inglês. Para falar com um intérprete, ligue para o número de atendimento ao beneficiário indicado no verso do seu cartão.

We speak your language

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