Schedule of Benefits for Business BlueEssentials℠
PPO Silver 1
This Contract provides benefits for Covered Services received in-Network and out-of-Network.

Employer Name:	THE EASTER SEAL SOCIETY OF SC		
Client Effective Date:	November 01, 2014	Client Number:	49329
Anniversary Date:	November 01	Group Number:	65-20516-00
Benefit Period:	November 1st through October 31st	Coverage Effective Date:	November 01, 2016

Copayments – You Pay	$30 per Primary Care Physician (PCP)* Office Visit $60 per Specialist* Office Visit $60 per Urgent Care Center Visit $200 per Emergency Room (ER) Visit subject to the Deductible and Coinsurance *Copayments for Primary Care Physicians and Specialists are In-network only. Copayments apply toward the Maximum Out-of-pocket and stops when the Maximum Out-of-pocket is reached. Copayments do not apply to the Deductible.
Deductible – You Pay	Network Providers – $2,250 per Member or $4,500 per Family per Benefit Period. With Family coverage, once a person meets a $2,250 Deductible, benefits will begin paying for that person. Out-of-Network Providers – There is no Deductible The Deductible applies to all Covered Services except Preventive Care, Primary Care Physician Office Visit, Specialist Office Visit, Urgent Care Center Visit and Prescription Drugs. The Deductible applies to the Maximum Out-of-pocket.
Maximum Out-of-Pocket – You Pay	Network Providers – $6,850 per Member or $13,700 per Family per Benefit Period. Out-of-Network Provider – There is no Out-of-Pocket Limit Covered Services will be paid at 100% from Network Providers after the Out-of-pocket Limit is met. With family coverage, once one Member meets a $6,850 Maximum Out-of-pocket, benefits are payable at 100% for that Member only. The Maximum Out-of-pocket includes Copayments, Deductibles and Coinsurance. It doesn't include premiums; charges in excess of the Allowed Amount; amounts exceeding any Maximum Payments for benefits; or any expense not allowed according to any provisions of this coverage.
Prescription Drug Deductible – You Pay	$0 per Member per Benefit Period for Tier 4 Prescription Drugs.
Benefit Period Maximum – We Pay (All Benefit Period Maximums are per Member per Benefit Period)	60 days for Skilled Nursing Facility Services 60 visits for Home Health Care 6 months per episode for Inpatient and Outpatient Hospice Care 30 visits for Physical, Speech and Occupational Therapy Services combined – other than Inpatient

There are no dollar limits on Essential Health Benefits.

All benefits payable on Covered Services are based on our Allowed Amount. All Covered Services must be Medically Necessary. All admissions require Preauthorization. Certain other services also require Preauthorization. See the Preauthorization section of the Certificate for information concerning the Preauthorization requirement.

For some services to be covered, you will be required to use a Provider we designate, who may or may not be a BlueEssentials Provider. These services include transplants, mammography, Habilitation, Rehabilitation and vision care.

The coverage described herein meets the actuarial requirements of the Silver level of benefits.

Our plan has free language interpretation services available. We can also give you information in languages other than English, in large print or other alternate formats.

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Services that are covered for you	What you must pay when you get these services		
	In-Network *Retail Pharmacy*	In-Network *Mail-Order Pharmacy*	Out-of-Network *Retail Pharmacy*
Prescription Drugs – Must be purchased at Network Name Per prescription or refill			
Tier 0 Drugs – Drugs in this tier are considered preventive medications under the Affordable Care Act (ACA) and are covered at no cost to you.	$0 Copayment	$0 Copayment	50%
Tier 1 Drugs and designated Over-the-counter Drugs – These drugs are most often generic and will generally cost you the least amount of money out of your pocket. Generic drugs have the same active ingredient(s) as brand-name drugs, may have different inactive ingredients and are not manufactured under a registered brand name or trademark.	$15 Copayment	$21 Copayment	
Tier 2 Drugs – Drugs in this tier are most often brand-name drugs and are sometimes referred to as "preferred" drugs because they usually cost less than brand-name drugs in higher tier levels.	$40 Copayment	$108 Copayment	
Tier 3 Drugs – Drugs on this tier are most often brand-name drugs that may have generic equivalents. They are sometimes referred to as non-preferred because there is usually a lower cost alternative available.	$100 Copayment	$270 Copayment	
Tier 4 Drugs – These are typically drugs that are used in the management of chronic or genetic disease, including but not limited to injectable, infused or oral medications; or, products that otherwise require special handling, refrigeration and special training. You will usually pay more for drugs in this tier than drugs in lower tiers.	10% up to $200	No Benefits	No Benefits
	Benefits are limited to a 31-day supply. You may purchase a 90-day supply at a retail pharmacy that is a part of our Retail 90 Pharmacy Network. The mail-order pharmacy benefit will apply to the retail pharmacy.	Benefits are limited to a 90-day supply.	No Benefits for Out-of-Network Mail-Order Pharmacy.
Some drugs are considered specialty medications and must be filled at our Specialty Pharmacy. Although most specialty drugs are found in tier 4, they could be tier 1, 2 or 3. Please see the Business BlueEssentials Covered Drug List for the list of drugs that must be filled with the Specialty Pharmacy.			
If a Physician prescribes a Brand-name Drug and there is an equivalent Generic Drug available (whether or not the Physician allows substitution of the Brand-name Drug), then the Member must pay any difference between the cost of the Generic Drug and the higher cost of the Brand-name Drug. The difference you must pay between the cost of the Generic Drug and the higher cost of the Brand-name Drug does not apply to your Deductible or your Maximum Out-of-pocket.			

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Services that are covered for you	What you must pay when you get these services	
	Network	**Out-of-Network**
Primary Care Physician, Specialist Services or Urgent Care Facility		
Office Visit Services – Office charges for the treatment of an accident or injury; injections for allergy and antibiotics; diagnostic lab and diagnostic X-ray services (such as chest X-rays and standard plain film X-rays), when performed in the Physician's office on the same date and billed by the Physician (excluding Maternity Care)	0% after Copayment	50%
Inpatient Physician and Surgical Services	20% after Deductible	50%
All Other Physician Services – Outpatient Hospital; Skilled Nursing Facility; Clinic; Lab, X-ray, and the reading/interpretation of diagnostic lab and X-ray services; Surgery, male sterilization; Second Surgical Opinion; consultation; anesthesia; dialysis treatment, chemotherapy, and radiation therapy and administration of Specialty Drugs .	20% after Deductible	50%
Urgent Care Facilities – The facility must be licensed as an Urgent Care Facility.	0% after Copayment	50%
Preventive Services		
The following are covered: • The United States Preventive Services Task Force (USPSTF) recommended Grade A or B screenings. • Immunizations as recommended by the Centers for Disease Control (CDC). • Screenings recommended for children and women by Health Resources and Services Administration (HRSA) • Preventive prostate screening and laboratory work according to the American Cancer Society (ACS) • Preventive yearly Pap Smear or more often if recommended by a Physician • Preventive Mammography • Lactation support and counseling. Includes breast pump when purchased through a doctor's office, Pharmacy or DME supplier and is limited to one pump every 12 months • Female sterilization • The following contraceptive devices or services: generic injections, Mirena IUD, Nexplanon implant, Ortho Evra patch, Nuvaring, Ortho Flex, Ortho Coil, Ortho Flat, Wide-seal, Omniflex, Prentif and Femcap-vaginal • Preventive Care (except Preventive Pap Smear) must meet the age and/or condition guidelines/recommendations of the USPSTF, CDC, HRSA or ACA to be converted at no cost to the member.	$0	No Benefits
All other covered contraceptive devices or services not specifically listed above	20% after Deductible	50%
Laboratory and Diagnostic Services		
Radiology, ultrasound and nuclear medicine; laboratory and pathology; ECG, EEG and other electronic diagnostic medical procedures and physiological medical testing; Endoscopies (such as colonoscopy, proctoscopy and laparoscopy); High technology diagnostic services such as, but not limited to, MRIs, MRAs, PET scans, CT scans, cardiac catheterizations, and procedures performed with contrast or dye.	20% after Deductible	50%

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Services that are covered for you	What you must pay when you get these services	
	Network	**Out-of-Network**
Hospital Services		
Inpatient and outpatient Hospital (other than Skilled Nursing Facilities, Rehabilitation Facilities or Emergency Room). Including Mental Health and Substance Use Disorder Services.	20% after Deductible	50%
Emergency Services		
Emergency Room Charges	20% after Copayment and Deductible	20% after Copayment and Deductible
Ambulance, Out-of-Area (including Physician services)	20% after Deductible	50%
Maternity		
Pre- and post-natal care including Physician. Hospital services are the same as shown above.	20% after Deductible	50%
Newborn Care		
Post-natal care including Physician services. Hospital services provided as shown above. Benefits will be available only if the child is added to your Contract.	20% after Deductible	50%
Pediatric Services – For members 19 and under		
Preventive Care – Grade A or B screenings as recommended by the United States Preventive Services Task Force (USPSTF)	$0	No Benefits
Immunizations – As recommended by the Centers for Disease Control (CDC)	$0	No Benefits
Routine Vision Services • Eye Exam – limited to one exam per Benefit Period • Eyeglasses – frames limited to once every two years and lenses per Benefit Period. • Contacts only when Medically Necessary Pediatric Vision Services are provided through VSP. VSP is a separate company that provides Pediatric Vision Services on behalf of Blue Cross and Blue Shield of South Carolina. To find a VSP Provider, go to www.vsp.com/advantage and enter your ZIP code. Please note that any copayment made will be applied to your Maximum Out-of-pocket.	$0 after $25 Copayment $0 after $50 Copayment	No Benefits

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Services that are covered for you	What you must pay when you get these services	
	Network	**Out-of-Network**
Rehabilitative and Habilitative		
Durable Medical Equipment (DME) – purchase or rental – excludes repair of, replacement of and duplicate DME.	20% after Deductible	No Benefits
Physical, occupational, speech and respiratory therapy	20% after Deductible	50%
Rehabilitation including cardiac and pulmonary	20% after Deductible	50%
Skilled Nursing and Rehabilitation Facilities	20% after Deductible	50%
Medical Supplies	20% after Deductible	50%
Mental Health & Substance Use Disorder Services		
Inpatient and Physician's Services	Paid same as Hospital Services	50%
Outpatient and Physician's Services	Paid same as Hospital Services	50%
Residential Treatment Centers	20% after Deductible	50%
Physician's Office	Paid same as Primary Care Physician	50%
Other Services		
Dental Services Related to Accidental Injury – Only when such care is for treatment, Surgery or appliances caused by accidental bodily injury (except dental injuries occurring through the natural act of chewing). It's limited to care completed within six months of such accident and while the patient is still covered under this Policy.	20% after Deductible	50%
Home Health Care	20% after Deductible	50%
Hospice Care	20% after Deductible	50%
Out-of-Country Services including facility and Physician (Covered through a BlueCard® Provider Only)	20% after Deductible	50%