SCHEDULE OF BENEFITS FOR BUSINESS BLUE[SM] HIGH DEDUCTIBLE

Employer Name: SC CAMPAIGN TO PREVENT TEEN PREGNANCY
Client Number: 34918 Group Number: 05-57443-01
Client Effective Date: July 1, 2007 Coverage Effective Date: July 1, 2017
Anniversary Date: July 01
Benefit Period: July 1 through June 30th

Deductible - You pay	$2600 for Single (individual) coverage or $5200 for Family coverage each Benefit Period Deductible amounts do apply to the Out-of-pocket Expense.
Out-of-pocket Expenses - You pay	Preferred Blue® Providers - $2600 for Single (individual) coverage or $5200 for Family coverage for Deductible and/or Coinsurance amounts per Benefit Period Covered Expenses will be paid at 100% from Preferred Blue Providers after the Out-of-pocket Maximum is met. All Other Providers - $5200 for Single (individual) coverage or $10400 for Family coverage for Deductible and/or Coinsurance amounts per Benefit Period Covered Expenses will be paid at 100% from All Other Providers after the Out-of-pocket Maximum is met. Out-of-pocket Covered Expenses contribute to both Out-of-pocket Maximums.
Maximum Benefit - We pay	Per Member per Benefit Period: 30 visits for physical therapy, other than inpatient 60 visits for Home Health Care 7 Inpatient days for Mental Health Services/Substance Abuse care 25 Outpatient/office visits for Mental Health Services/Substance Abuse care (combined office, outpatient Facility and Physician) 60 days for Skilled Nursing Facility Separate per Member Benefit Period Maximums apply to the following: 6 months per episode for Hospice Care $500 for spinal subluxation services (if purchased) $300 for physical exam services not included in other covered Preventive Screenings (if purchased)

All benefits payable on Covered Expenses are based on our Allowable Charges.
All covered services must be Medically Necessary.

All Admissions require Preadmission Review or Emergency Admission Review, and Continued Stay Review. If Preadmission Review is not obtained for all Facility Admissions, room and board will be denied. If approval is not obtained for Emergency Admissions within 24 hours or by 5 p.m. of the next working day following the Admission, room and board will be denied.

Treatment for the following outpatient services require Preauthorization Review: covered Mental Health Services and covered Substance Abuse care, chemotherapy or radiation therapy (first treatment only), hysterectomy and septoplasty. If Preauthorization is not obtained, appropriate Benefits will be paid after a 50% reduction in the Allowable Charge.

All cosmetic Surgery or procedures, Home Health Care, Hospice Care, human organ and/or tissue transplants, inpatient rehabilitation services, Prosthetic Devices and Durable Medical Equipment (DME) when the purchase price or total rental cost of the DME is $500 or more require Preauthorization Review. If Preauthorization is not obtained, no Benefits will be paid. Inpatient rehabilitation services and human organ and/or tissue transplants must also be performed at a Designated Provider.

Services or medications for the treatment related to the management of all types of blood clotting or coagulation disorders, such as, but not limited to hemophilia must have care coordinated through a Center for Disease Control and Prevention (CDC) designated Hemophilia Treatment Center at least once per Benefit Period or Benefits will be paid after a 50% reduction in the Allowable Charge.

The following procedures require Preauthorization Review when performed outpatient or in the office: MRI, MRA, PET scan and CT scan. Please call National Imaging Associates (NIA) at 866-500-7664 for Preauthorization Review. If Preauthorization Review is not obtained, no Benefits will be paid. On behalf of Blue Cross® and Blue Shield® of South Carolina, National Imaging Associates (NIA) provides utilization management services for certain radiological procedures. National Imaging Associates is an independent company that preauthorizes certain radiological procedures.

For all other medical services that require Preauthorization Review and all Facility Admissions, please call 803-736-5990 in the Columbia area, 800-327-3238 toll-free in South Carolina and 800-334-7287 toll-free outside South Carolina. For Preauthorization Review for all Mental Health Services and Substance Abuse care, please call Companion Benefit Alternatives, Inc. at 803-699-7308 in the Columbia area and 800-868-1032 toll-free outside of Columbia. On behalf of Blue Cross and Blue Shield of South Carolina, Companion Benefit Alternatives, Inc. (CBA) preauthorizes Mental Health Services and Substance Abuse care. Companion Benefit Alternatives, Inc. is a separate company that preauthorizes behavioral health benefits.

	WE PAY CONTRACTING MAIL SERVICE PHARMACY	**WE PAY PARTICIPATING NETWORK PHARMACIES**	**WE PAY NON-PARTICIPATING NETWORK PHARMACIES**
PRESCRIPTION DRUGS			
Blue Rx℠			
Generic, Preferred and Non-Preferred Drugs	100% after the Deductible for each prescription or refill. Contraceptives are included. Benefits are limited to a 90-day supply. Only generic oral contraceptives are covered at 100%, no Deductible or Coinsurance. Refer to above described regular prescription benefits for Brand-named oral contraceptives.	100% after the Deductible for each prescription or refill including designated Over-the-counter Drugs. Contraceptives are included. Benefits are limited to a 31-day supply. Only generic oral contraceptives are covered at 100%, no Deductible or Coinsurance. Refer to above described regular prescription benefits for Brand-named oral contraceptives.	60% after the Deductible for each prescription or refill including designated Over-the-counter Drugs. Contraceptives are included. Benefits are limited to a 31-day supply.

If a Physician prescribes a Brand-name Drug for a specific medical reason and states there is to be no substitution of that drug, then Benefits are payable as specified in the Schedule of Benefits. If a Physician allows the substitution of a Brand-name Drug and the Member still requests the Brand-name Drug, then the Member must pay any difference between the cost of a Generic Drug and the higher cost of a Brand-name Drug.

	WE PAY SPECIALTY DRUG NETWORK PROVIDERS	**WE PAY ALL OTHER PHARMACY PROVIDERS**
Specialty Drugs	100% after the Deductible, not to exceed the amount for which prior approval was given.	No Benefits

	WE PAY PREFERRED BLUE PROVIDERS	**WE PAY ALL OTHER PROVIDERS**
Physician Services		
Physician charges for services in an outpatient Hospital or Clinic, including Surgery, (except Mental Health Services, Substance Abuse care and physical therapy), outpatient lab and X-ray services and all other miscellaneous services	100% after the Deductible	60% after the Deductible
Physician non-routine/sick office charges to include the following: surgical services if for the treatment of an accident or injury; injections for allergy, tetanus 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 (does not include Mental Health Services and Substance Abuse care)	100% after the Deductible	60% after the Deductible

	WE PAY PREFERRED BLUE PROVIDERS	**WE PAY ALL OTHER PROVIDERS**
Physician Services (continued)		
Physician office charges for all other services, including Surgery, Second Surgical Opinion, consultation, dialysis treatment, chemotherapy and radiation therapy and Specialty Drugs received or dispensed in a Physician's office (including the administration) and the reading/interpretation of diagnostic lab and X-ray services	100% after the Deductible	60% after the Deductible
Endoscopies (such as proctoscopy and laparoscopy) performed in a Physician's office, whether for diagnosis or treatment	100% after the Deductible	60% after the Deductible
High technology diagnostic services such as, but not limited to, MRIs, MRAs, PET scans, CT scans, ultrasounds, cardiac catheterizations, and procedures performed with contrast or dye	100% after the Deductible	60% after the Deductible
Preventive screenings according to: United States Preventive Services Task Force (USPSTF) recommendations A or B, Center for Disease Control and Prevention (CDC) recommendations for immunizations, Health Resources and Services Administration (HRSA) recommendations for children and women preventive care and screenings and American Cancer Society guidelines for prostate screening/lab work	100%	No Benefits
Services related to a physical exam not included in other covered Preventive Screenings (limited to $300 per Benefit Period)	Not Purchased	No Benefits
Inpatient Physician charges for admissions in a Hospital (including initial newborn pediatric exam) and Skilled Nursing Facility, Surgery, anesthesia, radiology and pathology services (except Mental Health Services and Substance Abuse care)	100% after the Deductible	60% after the Deductible
Other Services		
Durable Medical Equipment (DME), which includes Orthotic Devices (purchase or total rental; excludes repair of, replacement of and duplicate DME - Preauthorization is required if $500 or more)	100% after the Deductible	No Benefits
Ambulance, Prosthetic Devices (limited to $50,000 per Benefit Period - Preauthorization is required), medical supplies, Ostomy Supplies, physical therapy (limited to 30 visits per Benefit Period, other than inpatient) and all other charges for out-of-country services or supplies (including outpatient Facility and Physician)	100% after the Deductible	60% after the Deductible
Hospice Care (limited to 6 months per episode - combined inpatient and outpatient) and Home Health Care (limited to 60 visits per Benefit Period), with the required Preauthorization - the physical therapy visit maximum applies	100% after the Deductible	60% after the Deductible
Human Organ and Tissue Transplants - when preapproved by the Corporation and performed at a Designated Provider, Benefits are payable for all expenses for medical and surgical services and supplies while covered under this Contract	100% after the Deductible	No Benefits
Spinal subluxation services (limited to $500 per Benefit Period)	Not Purchased	Not Purchased

	WE PAY PREFERRED BLUE PROVIDERS	**WE PAY ALL OTHER PROVIDERS**
Women's Preventive		
Facility charges billed separately and directly related to ligation, transection or occlusion of fallopian tubes	100%	60% after the Deductible
Physician, lab and X-ray charges directly related to ligation, transection or occlusion of fallopian tubes	100%	60% after the Deductible
Breastfeeding equipment - purchase only; through a doctor's office, Pharmacy or Durable Medical Equipment supplier only. Limited to one per twelve month period.	100%	No Benefits
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	100%	60% after the Deductible
All other covered contraceptive devices or services not specifically listed	100% after the Deductible	60% after the Deductible
Mental Health Services/Substance Abuse Benefits Combined		
Inpatient Facility charges (limited to 7 days per Benefit Period, combined Facility/Physician)	100% after the Deductible	60% after the Deductible
Inpatient Physician charges (limited to 7 days per Benefit Period, combined Facility/Physician)	100% after the Deductible	60% after the Deductible
Outpatient Hospital/Clinic and outpatient/office Physician charges (limited to 25 visits per Benefit Period, combined all outpatient/office charges)	100% after the Deductible	60% after the Deductible
Emergency Room charges (limited to 25 visits per Benefit Period, combined with outpatient/office charges)	100% after the Deductible	100% after the Deductible
Facility Benefits		
Inpatient Hospital (other than for Mental Health Services or Substance Abuse care), Skilled Nursing Facility (limited to 60 days per Benefit Period) and out-of-country Facility charges	100% after the Deductible	60% after the Deductible
Inpatient Rehabilitation services (must be Preauthorized by the Corporation and performed at a Designated Provider)	100% after the Deductible	60% after the Deductible
Outpatient Hospital (other than Emergency Room) or Clinic charges for medical and surgical services, preadmission testing, lab and X-ray services and all other miscellaneous services	100% after the Deductible	60% after the Deductible
Emergency Room charges	100% after the Deductible	100% after the Deductible

	WE PAY MAMMOGRAPHY NETWORK PROVIDER	**WE PAY ALL OTHER PROVIDERS**
Mammography Benefits		
Routine mammography screening according to the United States Preventive Services Task Force (USPSTF) recommendations A or B	100%	No Benefits