

Schedule of Benefits for Business BlueSM Chamber PREFERRED 6

Employer Name: Elauwit
Client Effective Date: April 1, 2014
Anniversary Date: January 01
Benefit Period: April 1st through March 31st

Client Number:
Group Number:
Coverage Effective Date: April 1, 2015

Copayment - You Pay

\$ 20 - Primary Care Physician (PCP)* office visit
\$40 - Specialist* office visit

*Copayments for Primary Care Physicians and Specialists are In-network only.

Applies toward the Out-of-pocket Limit and stops when the Out-of-pocket Limit is reached.

Deductible - You Pay

Network Providers - \$ 2,000 for Single (individual) coverage or \$6,000 for Family coverage each Benefit Period

Out-of-Network Providers - \$4,000 for Single (individual) coverage or \$1 2,000 for Family coverage each Benefit Period

The Network Provider Deductible does not apply to the Out-of-Network Provider Deductible.

The Out-of-Network Provider Deductible does not apply to the Network Provider Deductible.

Deductible amount applies to the Out-of-pocket Limit.

Out-of-pocket Limit - You Pay

Network Providers - \$5,000 for Single (individual) coverage or \$10,000 for Family coverage each Benefit Period

Out-of-Network Providers - \$10,000 for Single (individual) coverage or \$ 20,000 for Family coverage each Benefit Period

The Network Provider Out-of-pocket does not apply to the Out-of-Network Provider Out-of pocket.

The Out-of-Network Provider Out-of-pocket does not apply to the Network Provider Out-of pocket.

Covered Services will be paid at 100% after the Out-of-pocket Limit is met.

Benefit Period Maximum - We Pay

(All Benefit Period Maximums are per Member per Benefit Period)

60 days for Skilled Nursing Facility

60 visits for Home Health Care

6 months per episode for Hospice Care

30 visits for physical, speech and occupational therapy, combined

\$300 for physical e7am services not included in other covered Preventive Screenings

\$53,100 for Autism Spectrum Disorder

There is no annual or lifetime dollar limits on Essential Health Benefits provided.

All benefits payable on Covered Services are based on our Allowed Amounts. All Covered Services must be Medically Necessary. Please refer to the Certificate for services that require Preauthorization.

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(continued)

Services that are covered for you	What you must pay when you get these services	
	Network	Out-of-Network
Prescription Drugs	Per prescription or refill	
Retail Pharmacy - Limited to 31-day supply or 90-day supply with 3 Copayments when a Copayment applies.		
- Generic Drugs and designated Over-the-counter	\$8 Copayment	\$8 Copayment then 50% Coinsurance
Drugs - Generic Oral birth control	\$0	\$8 Copayment then 50% Coinsurance
- Preferred Drugs including oral birth control	\$30 Copayment	\$30 Copayment then 50% Coinsurance
- Non-preferred Drugs including oral birth control	\$60 Copayment	Coinsurance \$60 Copayment then 50% Coinsurance
Mail-service Pharmacy - Limited to a 90-day supply		
- Generic Drugs	\$16 Copayment	
- Generic Oral birth control	\$0	
- Preferred Drugs including oral birth control	\$70 Copayment	
- Non-preferred Drugs including oral birth control	\$140 Copayment	No Benefits
Specialty Drugs - Specialty Drugs are available at the Specialty Network Pharmacy Only	10% up to \$ 200	
Primary Care Physician or Specialist Services		
Office Visit Services - Office charges 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 (including Maternity Care)	0% after the Copayment	50% after the Deductible
All other services - Lab, X-ray, and the reading/interpretation of diagnostic lab and X-ray services; Surgery; endoscopies (such as proctoscopy and laparoscopy); second surgical opinion; consultation; anesthesia; dialysis treatment, chemotherapy and radiation therapy and Specialty Drugs (including the administration)	30% after the Deductible	50% after the Deductible
Inpatient and Outpatient (other than office) Physician charges	30% after the Deductible	50% after the Deductible

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 provided as state above. 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.

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(continued)

Services that are covered for you	What you must pay when you get these services	
	Network	Out-of-Network
Preventive Services		
<ul style="list-style-type: none"> • United States Preventive Preventive Services Task Force (USPSTF) recommended Grade A or B screenings • Screenings recommended for children and women by Health Resources and Services Administration (HRSA) • Preventive prostate screening/lab work according to the American Cancer Society • Routine mammography screening according to the United States Preventive Services Task Force (USPSTF) recommended Grade A or B • Lactation support and counseling. Includes breast pump when purchased through a doctorCs office, Pharmacy or DME supplier and is limited to one pump every twelve months 	\$0	No Benefits
<ul style="list-style-type: none"> • Female sterilization <ul style="list-style-type: none"> - Physician, lab and X-ray charges directly related to ligation, transection or occlusion or fallopian tubes - Facility charges billed separately and directly related to ligation, transection or occlusion of fallopian tubes • The following contraceptive devices or services: generic injections, Mirena IUD, Ne7planon implant, Ortho Evra patch, Nuvaring, Ortho Fle7, Ortho Coil, Ortho Flat, Wide-seal, Omnifle7, Prentif 	\$0	50% after the Deductible
	\$0	Paid the same as Hospital Services
	\$0	50% after the Deductible
Contraceptive devices not specifically listed above	30% after the Deductible	50% after the Deductible
Services related to a physical e7am not included in other covered Preventive Screenings (limited to \$300 per Benefit Period. Services may be subject to age and visit limits.	\$0	No Benefits
Laboratory and Radiology Services		
Laboratory and pathology; radiology, ultrasound and nuclear medicine; ECG, EEG and other electronic diagnostic medical procedures and physiological medical testing; 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	30% after the Deductible	50% after the Deductible
Hospital Services (other than Skilled Nursing Facilities or Rehabilitation Facilities)		
Inpatient	30% after the Deductible	50% after the Deductible
Outpatient Hospital	30% after the Deductible	50% after the Deductible
Emergency Services		
Hospital Emergency Room charges	30% after the Deductible	30% after the Deductible
Ambulance, Out-of-Area (including Physician charges)	30% after the Deductible	50% after the Deductible

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(continued)

Services that are covered for you	What you must pay when you get these services	
	Network	Out-of-Network
Maternity		
Pre- and post-natal care including Physician and Hospital charges	30% after the Deductible	50% after the Deductible
Newborn Care		
Post-natal care including Physician and Hospital Charges	30% after the Deductible	50% after the Deductible
Rehabilitation Services		
Durable Medical Equipment (DME) - purchase or rental - includes repair of, replacement of and duplicate DME	30% after the Deductible	50% after the Deductible
Physical, occupational, speech and respiratory therapy	30% after the Deductible	50% after the Deductible
Rehabilitation including cardiac and pulmonary	30% after the Deductible	50% after the Deductible
Skilled Nursing and Rehabilitation Facilities	30% after the Deductible	50% after the Deductible
Medical Supplies	30% after the Deductible	50% after the Deductible
Mental Health/Substance Use Disorder Services		
Inpatient Facility and Physician charges	Paid same as Hospital Services	50% after the Deductible
Outpatient Facility/Clinic and Physician charges	Paid same as Hospital Services	50% after the Deductible
Physician office charges	Paid same as Primary Care Physician	50% after the Deductible
Autism Spectrum Disorder - Behavioral modification using applied behavioral analysis (ABA) by a Board Certified Behavioral Analyst or approved Provider. Behavioral therapy does not include educational or alternative programs such as, but not limited to: TEACCH, auditory integration therapy, highashi schools/daily life, facilitated communication, floor time, relationship development intervention (RDI), holding therapy, movement therapies, music therapy and pet therapy. Preauthorization of the treatment plan by Companion Benefit Alternatives, Inc. is required. On behalf of Blue Cross and Blue Shield of South Carolina, Companion Benefit Alternatives preauthorizes Mental Health Services and Substance Abuse services. Companion Benefit Alternatives is a separate company that preauthorizes behavioral health benefits.	30% after the Deductible	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
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). ITCs limited to care completed within 12 months of such accident and while the patient is still covered under this Policy.	30% after the Deductible	50% after the Deductible
Home Health Care	30% after the Deductible	50% after the Deductible
Hospice Care	30% after the Deductible	50% after the Deductible
Out-of-Country Services including facility and Physician	30% after the Deductible	50% after the Deductible

