Schedule of Benefits for Business Blue[SM] Chamber
PREFERRED 4

Employer Name: Elauwit
Client Effective Date: April 1, 2015
Anniversary Date: April 1
Benefit Period: April1st through March 31st

Client Number: 0
Group Number: 0
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 0ut-of-pocket Limit and stops when the 0ut-of-pocket Limit is reached.
Deductible - You Pay	Network Providers - $1,000 for Single (individual) coverage or $3,000 for Family coverage each Benefit Period 0ut-of-Network Providers - $ 2,000 for Single (individual) coverage or $6,000 for Family coverage each Benefit Period The Network Provider Deductible does not apply to the 0ut-of-Network Provider Deductible. The 0ut-of-Network Provider Deductible does not apply to the Network Provider Deductible. Deductible amount applies to the 0ut-of-pocket Limit.
Out-of-pocket Limit - You Pay	Network Providers - $3,000 for Single (individual) coverage or $6,000 for Family coverage each Benefit Period 0ut-of-Network Providers - $6,000 for Single (individual) coverage or $1 2,000 for Family coverage each Benefit Period The Network Provider 0ut-of-pocket does not apply to the 0ut-of-Network Provider 0ut-of pocket. The 0ut-of-Network Provider 0ut-of-pocket does not apply to the Network Provider 0ut-of pocket. Covered Services will be paid at 100% after the 0ut-of-pocket Limit is met.
Benefit Period Maximum - We Pay (All Benefit Period Ma7imums 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 Screenigs $53,100 for Autism Spectrum Disorder

There i s 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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PREFERRED 4
(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 0ver-the-counter	$8 Copayment	$8 Copayment then 40% Coinsurance
Drugs - Generic 0ral birth control	$0	$8 Copayment then 40% Coinsurance
- Preferred Drugs including oral birth control	$30 Copayment	$30 Copayment then 40% Coinsurance
- Non-preferred Drugs including oral birth control	$60 Copayment	$60 Copayment then 40% Coinsurance
Mail-service Pharmacy - Limited to a 90-day supply		
- Generic Drugs	$16 Copayment	
- Generic 0ral 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 0nly	10% up to $ 200	
Primary Care Physician or Specialist Services		
0ffice Visit Services - 0ffice charges for the treament 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 (e7cluding Maternity Care)	0% after the Copayment	40% 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 adminstration)	20% after the Deductible	40% after the Deductible
Inpatient and 0utpatient (other than office) Physician charges	20% after the Deductible	40% 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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PREFERRED 4
(continued)

Services that are covered for you	What you must pay when you get these services Network	Out-of-
Preventive Services		
• 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
• Female sterilization		
- Physician, lab and X-ray charges directly related to ligation, transection or occlusion or fallopian tubes	$0	40% after the Deductible
- Facility charges billed separately and directly related to ligation, transection or occlusion of fallopian tubes	$0	Paid the same as Hospital Services
• The following contraceptive devices or services: generic injections, Mirena IUD, Ne7planon implant, 0rtho Evra patch, Nuvaring, 0rtho Fle7, 0rtho Coil, 0rtho Flat, Wide-seal, 0mnifle7, Prentif	$0	40% after the Deductible
Contraceptive devices not specifically listed above	20% after the Deductible	40% 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	20% after the Deductible	40% after the Deductible
Hospital Services (other than Skilled Nursing Facilities or Rehabilitation Facilities)		
Inpatient	20% after the Deductible	40% after the Deductible
0utpatient Hospital	20% after the Deductible	40% after the Deductible
Emergency Services		
Hospital Emergency Room charges	20% after the Deductible	20% after the Deductible
Ambulance, 0ut-of-Area (including Physician charges)	20% after the Deductible	40% after the Deductible

Schedule of Benefits for Business Blue[SM] Chamber
PREFERRED 4
(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	20% after the Deductible	40% after the Deductible
Newborn Care		
Post-natal care including Physician and Hospital Charges	20% after the Deductible	40% after the Deductible
Rehabilitation Services		
Durable Medical Equipment (DME) - purchase or rental - e7cludes repair of, replacement of and duplicate DME	20% after the Deductible	40% after the Deductible
Physical, occupational, speech and repiratory therapy	20% after the Deductible	40% after the Deductible
Rehabilitation including cardiac and pulmonary	20% after the Deductible	40% after the Deductible
Skilled Nursing and Rehabilitation Facilities	20% after the Deductible	40% after the Deductible
Medical Supplies	20% after the Deductible	40% after the Deductible
Mental Health/Substance Use Disorder Services		
Inpatient Facility and Physician charges	Paid same as Hospital Services	40% after the Deductible
0utpatient Facility/Clinic and Physician charges	Paid same as Hospital Services	40% after the Deductible
Physician office charges	Paid same as Primary Care Physician	40% 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, higashi schools/daily life, facilitated communication, floor time, realtionship development intervention (RDI), holding therapy, movement therapies, music therapy and pet therapy. Preauthorization of the treatment plan by Companion Benefit Alternatives, Inc. is required. 0n 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.	20% after the Deductible	No Benefits

Schedule of Benefits for Business Blue[S] Chamber
PREFERRED 4

(continued)

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 - 0nly when such care is for treatment, Surgery or appliances caused by accidental bodily injury (e7cept dental injuries occuring through the natural act of chewing). ItCs limited to care completed within si7 months of such accident and while the patient is still covered under this Policy.	20% after the Deductible	40% after the Deductible
Home Health Care	20% after the Deductible	40% after the Deductible
Hospice Care	20% after the Deductible	40% after the Deductible
0ut-of-Country Services including facility and Physician	20% after the Deductible	40% after the Deductible