Schedule of Benefits for Business BlueEssentials℠ Gold 1

Employer Name:	Siempelkamp Nuclear Services, Inc.	Client Number:	47221
Client Effective Date:	January 1, 2014	Group Number:	65-19118-00
Anniversary Date:	January 01	Coverage Effective Date:	January 1, 2014
Benefit Period:	January 1st thru December 31st		

Copayments – You Pay	$15 Primary Care Physician (PCP)* Office Visit $30 Specialist* Office Visit $300 Emergency Room *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 – $1,200 for Single (individual) coverage or $2,250 for Family coverage each Benefit Period Out-of-Network Providers – There is no Deductible Deductible amount applies to the Out-of-pocket Limit.
Out-of-Pocket Limit – You Pay	Network Providers – $4,200 for Single (individual) coverage or $7,900 for Family coverage each Benefit Period Covered Services will be paid at 100% from Network Providers after the Out-of-pocket Limit is met. Out-of-Network Provider – There is no Out-of-Pocket Limit
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 is no annual or lifetime dollar limits on benefits provided.**

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

Schedule of Benefits for Business BlueEssentials℠ Gold 1

(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 Drugs	$10 Copayment	50%
– Generic Oral Birth Control	$0	
– Preferred Drugs including oral birth control	$35 Copayment	
– Non-preferred Drugs including oral birth control	$100 Copayment	
Mail Service Pharmacy – Limited to a 90-day supply		
– Generic Drugs and designated Over-the-counter Drugs	$14 Copayment	No Benefits
– Generic Oral Birth Control	$0	
– Preferred Drugs including oral birth control	$95 Copayment	
– Non-preferred Drugs including oral birth control	$270 Copayment	
Specialty Drugs – Specialty Drugs are available at the Specialty Network Pharmacy Only	$200 Copayment	

Schedule of Benefits for Business BlueEssentials℠ Gold 1

(continued)

Services that are covered for you	What you must pay when you get these services Network	 Out-of-Network
Primary Care Physician or Specialist		
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 (excluding Maternity Care)	0% after Copayment	50%
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)	20% after Deductible	50%
Inpatient and Outpatient (other than office) Physician charges	20% after Deductible	50%
Preventive Care		
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 • Preventive prostate screening and laboratory work according to the American Cancer Society • 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	$0	No Benefits
Contraceptive devices not specifically listed above	20% after Deductible	50%

Schedule of Benefits for Business BlueEssentials℠ Gold 1

(continued)

Services that are covered for you	What you must pay when you get these services Network	 Out-of-Network
Laboratory Services		
Outpatient laboratory and pathology	20% after Deductible	50%
Radiology, ultrasound and nuclear medicine; inpatient 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%
Hospital Services		
Inpatient and outpatient Hospital (other than Skilled Nursing Facilities or Rehabilitation Facilities)	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 charges)	20% after Deductible	50%
Maternity		
Pre- and post-natal care including Physician and Hospital charges.	20% after Deductible	50%
Newborn Care		
Post-natal care including Physician and Hospital charges	20% after Deductible	50%
Pediatric Services		
Preventive Care – Grade A or B screenings as recommended by the United States Preventive Services Task Force (USPSTF) 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 and lenses limited to once per Benefit Period. Contacts only when Medically Necessary	$25 Copayment $50 Copayment	No Benefits
Dental – Subject to a separate combined $50 Deductible per Benefit Period • Class I – Preventive/Diagnostic • Class II – Minor Restorative Services • Class III – Major Restorative Services • Class IV – Orthodontics (covered only when Medically Necessary)	 $0 30% after Deductible 50% after Deductible 50% after Deductible	 No Benefits

Schedule of Benefits for Business BlueEssentials℠ Gold 1

(continued)

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	50%
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%
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	20% after Deductible	50%