PEDIATRIC CLINIC

Proposal # 395346-01A

Business BlueEssentials PPO Silver 6	Network Providers (In Network)	Other Providers (Out of Network)
Deductible *With family coverage once one person meets his/her deductible, benefits will begin paying for that person.* *Single coverage* *Family coverage** **With Family coverage once one person meets the Single Deductible, benefits will begin paying subject to the Coinsurance level for that person.*	$2,150 $4,300	N/A
Coinsurance *After the deductible, here is how we pay all eligible charges:* *BlueCross pays:* *The Member pays:*	70% 30%	50% 50%
Maximum Out of Pocket *Once these limits are met, we pay all remaining covered expenses at 100%.* *Single coverage* *Family coverage** * With Family coverage once one Member meets the Single Maximum Out-of-pocket, benefits are payable at 100% for that Member only.	$6,850 $13,700	Unlimited
Copayments *Primary Care Physician* *Specialist* *Emergency Room (waived if admitted, inpatient copayment applies)*	$25 $50 $200 then deductible and coinsurance	Coinsurance Coinsurance $200 then coinsurance
Maternity	Ded & Coins	Coinsurance
Preventive Benefits *Covered according to:* *United States Preventive Services Task Force (USPSTF) recommendations Grade A or B* *Centers for Disease Control and Prevention (CDC) recommendations for immunizations* *Health Resources and Services Administration (HRSA) recommendations for children and women preventive care and screenings* *Preventive prostate screening and laboratory work according to the American Cancer Society (ACS)* These are independent organizations that provide health guideline information on behalf of BlueCross BlueShield of South Carolina.	Included	Not covered
Sustained Health Benefit (SHB) *Up to $300 for physical exam services not including listed Preventive Benefits.*	Included	Not covered

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Prescription Drugs *Drug Card* *Tier 1* *Tier 2* *Tier 3* *Tier 4* See attached sheet for benefit details.	 $15 $40 $100 10% up to $200	 Coinsurance Coinsurance Coinsurance Not covered
Mail-Order Drugs *Drug Card* *Tier 1* *Tier 2* *Tier 3*	 $21 $108 $270	 Not covered Not covered Not covered
Dental *See attached sheet for benefit details.*	Not Selected	Not Selected
Chiropractic Benefits (CHIRO) *Limited to $500 per member per Benefit Period.*	Not Selected	Not Selected

South Carolina