Member Schedule

Benefits are available In-Network and Out-of-Network.

Employer's Name:	**Client Number:**
Client Effective Date:	**Group Number:**
Anniversary Date:	**Coverage Effective Date:**
Benefit Period:	

DEDUCTIBLE

Network Providers – $1,500 per Member per Benefit Perio and **$3,000** per family per Benefit Period. With family coverage, once one person meets a **$1,500** Deductible, benefits will begin paying for that person

Out-of-Network Provider – There is no Deductible

The Deductible applies to all Covered Services except Preventive Care and Primary Care Physician Office visit whe the Copayment applies to that visit. The Deductible applies to the Maximum Out-of-pocket.

COINSURANCE

Network Providers – The Percentage of the Allowed Amount that you pay for Covered Services. You pay **20%** of the Allowed Amount until you reach the Maximum Out-of-pocket.

Out-of-Network Providers – You pay 50% of the Allowed Amount.

COPAYMENTS

$20 per Primary Care Physician (PCP)* Office Visit

$10 per Blue CareOnDemand℠ Visit

$50 per Specialist* Office Visit

$50 per Urgent Care Center Visit

$300 per Emergency Room (ER) Visit subject to Deductible and Coinsurance

$500 per visit for surgery performed at an Ambulatory Surgical Center

*Copayments for PCP and Specialists are In-Network only

Copayments apply toward the Maximum Out-of-pocket and stops when the Maximum Out-of-pocket is reached.

Copayments do not apply to the Deductible.

MAXIMUM OUT-OF-POCKET

Network Providers – $4,500 per Member per Benefit Period and **$9,000** per family per Benefit Period

Covered Services will be paid at 100% of the Allowable Charges when you reach your Maximum Out-of-pocket. With family coverage, once one Member meets a **$4,500** Maximum Out-of-pocket, benefits are payable a 100% for that Member only.

Out-of-Network Provider – There is no Out-of-Pocket Limit

The Maximum Out-of-pocket includes Copayments, Deductibles and Coinsurance. It does not include Premiums, Balance-billed charges or health care this Policy does not cover.

PRESCRIPTION DRUG COVERAGE

In-Network Retail: 31 day supply maximum

Tier 0: $0 Copayment
Tier 1: $12 Copayment
Tier 2: $50 Copayment
Tier 3: $100 Copayment
Tier 4: $300 Copayment

Out-of-Network Retail:

Tier 0: 50%
Tier 1/2/3: 50%
Tier 4: No Benefits

In-Network Retail Mail-Order: 90 day supply

Tier 0: $0 Copayment
Tier 1: $17 Copayment
Tier 2: $135 Copayment
Tier 3: $270 Copayment
Tier 4: No Benefits

Out-of-Network Retail: No Benefits for Out-of-Network Mail-Order pharmacy.

Some drugs are considered specialty medications and must be filled at our Specialty Pharmacy, BriovaRx®. Although most specialty drugs are found in Tier 4, they could be Tier 1, 2 or 3. Please see your Certificate for a description of the Tiers for further clarification. Also see the Business BlueEssentials Covered Drug List for the list of drugs that must be filled with the Specialty Pharmacy.

BENEFIT PERIOD MAXIMUM — Per Member Per Benefit Period

60 days for Skilled Nursing Facility
60 visits for Home Health Care
6 months per episode for Inpatient and Outpatient Hospice Care
30 Rehabilitative visits for Physical, Speech and Occupational Therapy Services combined
30 Habilitative visits for Physical, Speech and Occupational Therapy Services combined
$500 Sustained Health Benefit for physical exam services not included in other Preventive Screenings

There are no dollar limits on Essential Health Benefits.

All benefits payable on Covered Services are based on our allowed amount. All covered services must be medically necessary. Some services require preauthorization, including all hospital admissions, except maternity. See the preauthorization section of the Certificate for information concerning the preauthorization requirement.

For some services to be covered, you will be required to use a provider we designate, who may or may not be a Business BlueEssentials provider. These services include transplants, mammography, habilitation, rehabilitation and vision care.

This policy meets the actuarial requirements of the Gold level of benefits.

Our plan has free language interpretation services available. We can also give you information in languages other than English, in large print or other alternate formats.

Services That Are Covered For You

PRIMARY CARE PHYSICIAN, SPECIALIST OR URGENT CARE CENTERS

	In-Network	Out-of-Network
Office isit Services – Office charges for the treatment of an illness, 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- ays), when performed in the physician's office on the same date and billed by the physicia (excluding maternity). Includes mental health and substance use disorder services.	0% after Copayment	50%
Blue CareOnDemand℠	0% after Copayment	50%
Inpatient Physician and Surgical Services	20% after Deductible	50%
All Other Physician Services – Outpatient hospital; skilled nursing facility; clinics; lab, X-ray, and the reading/interpretation of diagnostic lab and X-ray services; surgery, male sterilization; second surgical opinion; consultation; anesthesia; dialysis treatment, chemotherapy, radiation therapy and the administration of specialty medications.	20% after Deductible	50%
Urgent Care Center – The facility must be licensed as an urgent care center.	0% after Copayment	50%

PREVENTIVE CARE FOR CHILDREN AND ADULTS

	In-Network	Out-of-Network
As outlined in your Contract as Preventive Care benefits. Includes some contraceptive devices or services.	$0	**No Benefits**
⊘ There are No Benefits for Preventive Care Out-of-Network.		
All other covered contraceptive devices or services not specifically listed in your Contract.	20% after Deductible	50%
Services related to a physical exam not included in other covered Preventive Screenings limited to $500 per Benefit Period. Services may be subject to age and visit limits.	$0	**No Benefits**
⊘ There are No Benefits for Sustained Health Out-of-Network.		

ROUTINE VISION SERVICES FOR MEMBERS AGE 19 AND YOUNGER

	In-Network	Out-of-Network
• Eye Exam – limited to one exam per benefit period	$0 after $25 Copayment	**No Benefits**
• Eyeglasses – frames and lenses limited to once every benefit period.	$0 after $50 Copayment	
• Contacts only when Medically Necessary.		
Pediatric Vision Services are provided through VSP. VSP is an independent company that provides Pediatric Vision Services on behalf of BlueCross BlueShield of South Carolina. To find a VSP provider, go to www.vsp.com/advantage and enter your ZIP code. (This link leads to a third-party site. That company is solely responsible for the contents and privacy policies on its site.)		
⊘ There are No Benefits for Routine Vision Services Out-of-Network.		

LABORATORY AND DIAGNOSTIC SERVICES

	In-Network	Out-of-Network
Radiology, ultrasound and nuclear medicine; 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

	In-Network	Out-of-Network
Inpatient and outpatient Hospital (other than Skilled Nursing Facilities, Rehabilitation Facilities or Emergency Room). Includes Mental Health and Substance Use Disorder Services.	20% after Deductible	50%
Ambulatory Surgical Center (ASC) facility charge - An ASC is a free-standing facility not affiliated with a health system that is licensed for Outpatient Services only and doesn't provide overnight accommodations or around-the-clock care.	0% after Copayment	50%

EMERGENCY SERVICES

	In-Network	Out-of-Network
Emergency room charges in- or out-of-network or out-of-area, including physician services in the Emergency Room (copayment applies only to Emergency Room charges)	20% after Copayment then Deductible	20% after Copayment then Deductible
Ambulance services in- or out-of-network or out-of-area, only when medically necessary	20% after Deductible	50%

MATERNITY

	In-Network	Out-of-Network
Pre- and post-partum care including Physician services. Hospital services provided as shown above.	20% after Deductible	50%

Expecting a new baby? Our free Maternity Care program can provide you with the tools and information you need to help get your baby off to a healthy start. To enroll, call 855-838-5897 and select option 4.

NEWBORN CARE

	In-Network	Out-of-Network
Post-natal care, including physician services. Hospital services provided as shown above. Benefits are available only if the child is added to you policy.	20% after Deductible	50%

REHABILITATIVE AND HABILITATIVE

	In-Network	Out-of-Network
Durable Medical Equipment (DME) - purchase or rental - excludes repair of, replacement of and duplicate DME.	20% after Deductible	**No Benefits**
There are no Out-of-Network benefits for DME		
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

	In-Network	Out-of-Network
Inpatient and physician's services	20% after Deductible	50%
Outpatient and physician's services	20% after Deductible	50%
Residential treatment centers	20% after Deductible	50%
Physician's office (same as Primary Care Physician (PCP) Office visit)	0% after Copayment	50%

OTHER SERVICES

	In-Network	Out-of-Network
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 (60-visit maximum)	20% after Deductible	50%
Hospice care (6 months per episode to include Inpatient and Outpatient care)	20% after Deductible	50%
Out-of-Country services including facility and physician for emergency and urgent care only, if covered through a BlueCard® provider.	20% after Deductible	50%