Business BlueEssentials PPO Silver 2	Network Providers (In Network)	Other Providers (Out of Network)
Deductible		
Single coverage	$1,100	N/A
*Family coverage**	$2,200	
**With Family coverage once one person meets the Single Deductible, benefits will begin paying subject to the Coinsurance level for that person.*		
Coinsurance		
After the deductible, here is how we pay all eligible charges:		
BlueCross pays:	50%	50%
The employee pays:	50%	50%
Maximum Out of Pocket		
Once these limits are met, we pay all remaining covered expenses at 100%.		
Single coverage	$8,150	Unlimited
*Family coverage**	$16,300	
* *With Family coverage once one Member meets the Single Maximum Out-of-pocket, benefits are payable at 100% for that Member only.*		
Blue CareOnDemand℠	$20	N/A
Primary Care		
Office Services	$30	Coinsurance
Urgent Care	$60	Coinsurance
Doctors Care	$30	N/A
Specialty Care		
Office Services	$60	Coinsurance
Mandated Preventive Care	$0	Not Covered
Maternity Care (prenatal and postnatal)	Ded & Coins	Coinsurance
Laboratory Outpatient & Professional Services	Ded & Coins	Coinsurance
X-rays and Diagnostic Imaging	Ded & Coins	Coinsurance
Imaging (CT/PET scans, MRIs)	Ded & Coins	Coinsurance
Other Routine Care		
GYN Exam - 1 per benefit period	$0	Not Covered
Routine Screening Mammogram	$0	Not Covered
Routine Screening Colonoscopy	$0	Not Covered
Sustained Health Benefits (SHB) *Up to $500 for physical exams not included in other Preventive Screenings per Benefit Period. Services subject to age and visit limits.*	Included	Not covered
Inpatient Hospital/Facility Services		
Inpatient hospital	Ded & Coins	Coinsurance
Outpatient Hospital/Facility Services		
Outpatient Services (includes Ambulatory Surgical Center)	Ded & Coins	Coinsurance
Freestanding Ambulatory Surgical Center	$500	Coinsurance
Outpatient Surgery Physician/Surgical services - medical	Ded & Coins	Coinsurance
Outpatient Services (Mental Health/Substance Abuse)	Ded & Coins	Coinsurance
Emergency Room	$300 then Ded & Coins	Same as In-Network

South Carolina

Business BlueEssentials PPO Silver 2	Network Providers (In Network)	Other Providers (Out of Network)
Human Organ Transplants *Services must be provided at a BlueCross BlueShield participating facility.*	Ded and Coins	Not Covered
Prescription Drugs		
Tier 0	$0	Coinsurance
Tier 1	$30	Coinsurance
Tier 2	$75	Coinsurance
Tier 3	$150	Coinsurance
Tier 4	$300	Not covered
Mail-Order Drugs		
Up to 90-day supply		
Tier 0	$0	Not covered
Tier 1	$42	Not covered
Tier 2	$203	Not covered
Tier 3	$405	Not covered
Dental	Not Selected	Not Selected
Chiropractic Benefits (CHIRO) *Limited to $500 per member per Benefit Period.*	Not Selected	Not Selected
Pediatric Vision Care – VSP Network **(VSP) Providers Only (Refer to Provider Directory)** (Vision Service Plan (VSP) is an independent company that provides vision services on behalf of BlueCross BlueShield of South Carolina.)		
One comprehensive vision exam per Calendar Year	$25	Not Covered
One pair of glasses (lenses and frames) per Calendar Year	$50	Not Covered

Plan Maximums	Plan maximums Per Member
Durable Medical Equipment	Up to purchase price
Habilitation for Physical, Speech and Occupational Therapy	30 visits per Benefit Period
Home Health	60 visits per Benefit Period
Hospice	6 months per episode
Rehabilitation for Physical, Speech and Occupational Therapy	30 visits per Benefit Period
Prosthetic Devices	1 item per episode
Skilled Nursing Facility	60 days per Benefit Period

South Carolina