

SCHEDULE OF BENEFITS FOR BUSINESS BLUESM COMPLETE

Employer Name: My Group Coverage
Client Number: 12345
Client Effective Date: April 15, 2012
Anniversary Date: April 15
Benefit Period: April 15th through April 14th

Group Number: 05-55555-55
Coverage Effective Date: April 15, 2012

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|---|--|
| Deductible - You pay | \$1500 each Benefit Period Limited to three Deductibles per Family. Does not apply to the Out-of-pocket Expense. |
| Copayment - You pay | \$20 Primary Care Physician (PCP) office visit - a PCP is a family doctor, general Physician, OB-GYN, pediatrician, osteopath or internal medicine Physician \$40 Specialist office visit \$250 per admission for All Other Providers Does not apply toward the Out-of-pocket Maximum and does not stop when the Out-of-pocket Maximum is reached |
| Specialty Drug Copayment - You pay | 10% not to exceed \$200 per Dose when obtained through a Specialty Drug Network Does not apply toward the Out-of-pocket Maximum and does not stop when the Out-of-pocket Maximum is reached. |
| Out-of-pocket Expenses - You pay | You pay Preferred Blue® Providers-\$3000 per Member or \$6000 per Family per Benefit Period Covered Expenses will be paid at 100% from Preferred Blue Providers after the Out-of-pocket Maximum is met except for Mental Health Services, Substance Abuse care and Spinal Subluxation Services (if purchased). All Other Providers - \$6000 per Member or \$12000 per Family per Benefit Period Covered Expenses will be paid at 100% from All Other Providers after the Out-of-pocket Maximum is met except for Mental Health Services, Substance Abuse care and Spinal Subluxation Services (if purchased). Out-of-pocket Covered Expenses contribute to both Out-of-pocket Maximums. Coinsurance for Mental Health Services, Substance Abuse care and Spinal Subluxation Services (if purchased) does not contribute to the Out-of-pocket Maximums, nor does the reimbursement percentage change from the amount indicated on the Schedule of Benefits. |
| Maximum Benefit - We pay | Per Member per Benefit Period: 30 visits for physical therapy, other than inpatient 60 visits for Home Health Care 7 Inpatient days for Mental Health Services/Substance Abuse care 25 Outpatient/office visits for Mental Health Services/Substance Abuse care (combined office, outpatient Facility and Physician) 60 days for Skilled Nursing Facility Separate per Member Benefit Period Maximums apply to the following: 6 months per episode for Hospice Care \$500 for spinal subluxation services (if purchased) \$500 for Supplemental Accidental Injury (if purchased) \$300 for physical exam services not included in other covered Preventive Screenings (if purchased) |

All benefits payable on Covered Expenses are based on our Allowable Charges
All covered services must be Medically Necessary.

All Admissions require Preadmission Review or Emergency Admission Review and Continued Stay Review. If Preadmission Review is not obtained for all Facility Admissions, room and board will be denied. If approval is not obtained for Emergency Admissions within 24 hours or by 5 p.m. of the next working day following the Admission, room and board will be denied.

Treatment for the following outpatient services require Preauthorization Review: covered Mental Health Services and covered Substance Abuse care, chemotherapy or radiation therapy (first treatment only), hysterectomy and septoplasty. If Preauthorization is not obtained, appropriate Benefits will be paid after a 50% reduction in the Allowable Charge.

SCHEDULE OF BENEFITS FOR BUSINESS BLUE COMPLETE (continued)

All cosmetic Surgery or procedures, Home Health Care, Hospice Care, human organ and/or tissue transplants, inpatient rehabilitation services, Prosthetic Devices and Durable Medical Equipment (DME) when the purchase price or total rental cost of the DME is \$500 or more require Preauthorization Review. If Preauthorization is not obtained, no Benefits will be paid. Inpatient rehabilitation services and human organ and/or tissue transplants must also be performed at a Designated Provider.

Services or medications for the treatment related to the management of all types of blood clotting or coagulation disorders, such as, but not limited to hemophilia must have care coordinated through a Center for Disease Control and Prevention (CDC) designated Hemophilia Treatment Center at least once per Benefit Period or Benefits will be paid after a 50% reduction in the Allowable Charge.

The following procedures require Preauthorization Review when performed outpatient or in the office: MRI, MRA, PET scan and CT scan. Please call National Imaging Associates (NIA) at 866-500-7664 for Preauthorization Review. If Preauthorization Review is not obtained, no Benefits will be paid. On behalf of Blue Cross® and Blue Shield® of South Carolina, National Imaging Associates (NIA) provides utilization management services for certain radiological procedures. National Imaging Associates is an independent company that preauthorizes certain radiological procedures.

For all other medical services that require Preauthorization Review and all Facility Admissions, please call 803-736-5990 in the Columbia area, 800-327-3238 toll-free in South Carolina and 800-334-7287 toll-free outside South Carolina. For Preauthorization Review for all Mental Health Services and Substance Abuse care, please call Companion Benefit Alternatives, Inc. at 803-699-7308 in the Columbia area and 800-868-1032 toll-free outside of Columbia. On behalf of Blue Cross and Blue Shield of South Carolina, Companion Benefit Alternatives, Inc. (CBA) preauthorizes Mental Health Services and Substance Abuse care. Companion Benefit Alternatives, Inc. is a separate company that preauthorizes behavioral health benefits.

WE PAY CONTRACTING MAIL SERVICE PHARMACY

WE PAY PARTICIPATING NETWORK PHARMACIES

WE PAY NON-PARTICIPATING NETWORK PHARMACIES

Prescription Drugs

Drug Card

Generic, Preferred and
Non-Preferred Drugs

100% per prescription or refill after you pay the Prescription Drug Copayment of:
\$16 for Generic Drugs
\$70 for Preferred Drugs
\$140 for Non-preferred Drugs
Contraceptives are included. Benefits are limited to a 90-day supply. Only generic oral contraceptives are covered at 100%, no Copayment. Refer to above described regular prescription benefits for Brand-named oral contraceptives.

100% per prescription or refill after you pay the Prescription Drug Copayment of:
\$8 for Generic and designated Over-the-counter Drugs
\$30 for Preferred Drugs
\$60 for Non-preferred Drugs
Contraceptives are included. Benefits are limited to a 31-day supply or a 90-day supply with 3 Prescription Drug Copayments.
Only generic oral contraceptives are covered at 100%, no Copayment. Refer to above described regular prescription benefits for Brand-named oral contraceptives.

60% per prescription or refill after you pay the Prescription Drug Copayment of:
\$8 for Generic and designated Over-the-counter Drugs
\$30 for Preferred Drugs
\$60 for Non-preferred Drugs
Contraceptives are included. Benefits are limited to a 31-day supply or a 90-day supply with 3 Prescription Drug Copayments.

SCHEDULE OF BENEFITS FOR BUSINESS BLUE COMPLETE
(continued)

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 payable as specified in the Schedule of Benefits. 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.

Specialty Drugs

**WE PAY
SPECIALTY DRUG
NETWORK
PROVIDERS**

100% after you pay each
Specialty
Drug Copayment, not to
exceed
the amount for which
prior
approval was given.

**WE PAY
ALL OTHER PHARMACY
PROVIDERS**

No Benefits

Physician Services

Physician charges for services in an outpatient Hospital or Clinic, including Surgery, (except Mental Health Services, Substance Abuse care and physical therapy), outpatient lab and X-ray services and all other miscellaneous services

80% after the Deductible

60% after the Deductible

Primary Care Physician (PCP) or Specialist non-routine/sick office charges to include the following: surgical services if 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 (does not include Mental Health Services, Substance Abuse care or maternity care)

100% after the
Copayment

60% after the Deductible

Physician office charges for all other services, including Surgery, Second Surgical Opinion, consultation, maternity care, dialysis treatment, chemotherapy and radiation therapy and Specialty Drugs received or dispensed in a Physician's office (including the administration) and the reading/interpretation of diagnostic lab and X-ray services

80% after the Deductible

60% after the Deductible

Endoscopies (such as proctoscopy and laparoscopy) performed in a Physician's office, whether for diagnosis or treatment

80% after the Deductible

60% after the Deductible

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

80% after the Deductible

60% after the Deductible

Preventive screenings according to: United States Preventive Se Task Force (USPSTF) recommendations A or B, Center for Dis Control and Prevention (CDC) recommendations for immunizat Health Resources and Services Administration (HRSA) recommendations for children and women preventive care and screenings and American Cancer Society guidelines for prostate screening/lab work

100%

No Benefits

SCHEDULE OF BENEFITS FOR BUSINESS BLUE COMPLETE
(continued)

**WE PAY
PREFERRED BLUE
PROVIDERS**

**WE PAY
ALL OTHER
PROVIDERS**

Physician Services (Continued)

Services related to a physical exam not included in other covered Preventive Screenings (limited to \$300 per Benefit Period)

100%

No Benefits

Inpatient Physician charges for admissions in a Hospital (including initial newborn pediatric exam) and Skilled Nursing Facility, Surgery, anesthesia, radiology and pathology services (except Mental Health Services and Substance Abuse care)

80% after the Deductible

60% after the Deductible

Other Services

Durable Medical Equipment (DME), which includes Orthotic Devices (purchase or total rental; excludes repair of, replacement of and duplicate DME - Preauthorization is required if \$500 or more)

80% after the Deductible

No Benefits

Ambulance, Prosthetic Devices (limited to \$50,000 per Benefit Period - Preauthorization is required), medical supplies, Ostomy

80% after the Deductible

60% after the Deductible

Supplies, physical therapy (limited to 30 visits per Benefit Period, other than inpatient) and all other charges for out-of-country services or supplies (including outpatient Facility and Physician)

Hospice Care (limited to 6 months per episode - combined inpatient and outpatient) and Home Health Care (limited to 60 visits per Benefit Period), with the required Preauthorization - the physical therapy visit maximum applies

80% after the Deductible

60% after the Deductible

Human Organ and Tissue Transplants - when preapproved by the Corporation and performed at a Designated Provider, Benefits are payable for all expenses for medical and surgical services and supplies while covered under this Contract

80% after the Deductible

No Benefits

Spinal subluxation services (limited to \$500 per Benefit Period)

Not Purchased

Not Purchased

Supplemental Accidental Injury (limited to \$500 per Benefit Period)

Not Purchased

Not Purchased

Women's Preventive

Facility charges billed separately and directly related to ligation, transection or occlusion of fallopian tubes

100%

Refer to Facility Benefits

Physician, lab and X-ray charges directly related to ligation, transection or occlusion of fallopian tubes

100%

60% after the Deductible

Breastfeeding equipment - purchase only; through a doctor's office, Pharmacy or Durable Medical Equipment supplier only. Limited to one per twelve month period.

100%

No Benefits

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

100%

60% after the Deductible

SCHEDULE OF BENEFITS FOR BUSINESS BLUE COMPLETE
(continued)

| | <u>WE PAY PREFERRED BLUE PROVIDERS</u> | <u>WE PAY ALL OTHER PROVIDERS</u> |
|--|---|--|
| <u>Women's Preventive (Continued)</u> | | |
| All other covered contraceptive devices or services not specifically listed | 80% after the Deductible | 60% after the Deductible |
| <u>Mental Health Services/Substance Abuse Benefits Combined</u> | | |
| Inpatient Facility charges (limited to 7 days per Benefit Period, combined Facility/Physician) | 80% | 60% after the Copayment and the Deductible |
| Inpatient Physician charges (limited to 7 days per Benefit Period, combined Facility/Physician) | 80% after the Deductible | 60% after the Deductible |
| Outpatient Hospital/Clinic and outpatient/office Physician charges (limited to 25 visits per Benefit Period, combined all outpatient/office charges) | 80% after the Deductible | 60% after the Deductible |
| Emergency Room charges (limited to 25 visits per Benefit Period, combined with outpatient/office charges) | 80% after the Deductible | 80% after the Deductible |
| <u>Facility Benefits</u> | | |
| Inpatient Hospital (other than for Mental Health Services or Substance Abuse care), Skilled Nursing Facility (limited to 60 days per Benefit Period) and out-of-country Facility charges | 80% | 60% after the Copayment and the Deductible |
| Inpatient Rehabilitation services (must be Preauthorized by the Corporation and performed at a Designated Provider) | 80% | 60% after the Copayment and the Deductible |
| Outpatient Hospital (other than Emergency Room) or Clinic charges for medical and surgical services, preadmission testing, lab and X-ray services and all other miscellaneous services | 80% after the Deductible | 60% after the Deductible |
| Emergency Room charges | 80% after the Deductible | 60% after the Deductible |
| <u>Mammography Benefits</u> | | |
| Routine mammography screening according to the United States Preventive Services Task Force (USPSTF) recommendations A or B | 100% | No Benefits |