ATTACHMENT C: SCHEDULE OF BENEFITS

Group Name: Example G13
Group Number: 123456
Effective Date: February 1, 2014
Network: Blue Network S

PLEASE READ THIS IMPORTANT STATEMENT: Network Benefits apply to services received from Network Providers and Non-Contracted Providers. **Out-of-Network benefit percentages apply to BlueCross Maximum Allowable Charge, not to the Provider's billed charge. When using Out-of-Network Providers, the Member must pay the difference between the Provider's price and the Maximum Allowable Charge. This amount can be substantial.** For more information, please refer to the definitions of Coinsurance and Maximum Allowable Charge in the Definitions section of this EOC.

Covered Services	Network Benefits for Covered Services received from Network Providers	Out-of-Network Benefits for Covered Services received from Out-of-Network Providers
Preventive Care		
Preventive/Well Care Services Includes: • Preventive health exam for child or adult • Well woman exam • Screenings (includes screenings with an A or B recommendation by the United States Preventive Services Task Force (USPSTF), Bright Futures recommendations for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA), and screenings for women as provided in the guidelines supported by HRSA). Examples include but are not limited to screening for breast cancer, cervical cancer, prostate cancer, colorectal cancer, high cholesterol, sexually transmitted infections. • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC). • Preventive counseling services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF) (Alcohol misuse and tobacco use counseling limited to eight (8) visits annually; must be provided in the primary care setting) (Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, coronary artery disease and congestive heart failure limited to six (6) visits annually.)	100%	50% of the Maximum Allowable Charge after Deductible

Covered Services	Network Benefits for Covered Services received from Network Providers	Out-of-Network Benefits for Covered Services received from Out-of-Network Providers
Lactation counseling by a trained provider during pregnancy or in the post-partum period. Limited to one (1) visit per pregnancy.	100%	50% of the Maximum Allowable Charge after Deductible
Manual breast pump, limited to one (1) per pregnancy	100%	50% of the Maximum Allowable Charge after Deductible
FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity.	100%	50% of the Maximum Allowable Charge after Deductible
Screening colonoscopy or screening flexible sigmoidoscopy For non-screening colonoscopy or sigmoidoscopy benefits, see **Office Surgery** under **Practitioner Office Visits** section or **Outpatient Facility Services Outpatient Surgery**	100%	50% of the Maximum Allowable Charge after Deductible
Practitioner Office Visits (except for Preventive Care)		
Diagnosis and treatment of illness or injury	100% after $45 Copayment	50% of the Maximum Allowable Charge after Deductible
Maternity care	100% after $45 Copayment	50% of the Maximum Allowable Charge after Deductible
Allergy testing	100%	50% of the Maximum Allowable Charge after Deductible
Allergy injections and allergy extract	100%	50% of the Maximum Allowable Charge after Deductible
Provider-Administered Specialty Drugs	100% after $200 Copayment	50% of the Maximum Allowable Charge after Deductible
All other medicine injections, excluding Specialty Drugs. For surgery injections, please see **Office Surgery**.	100%	50% of the Maximum Allowable Charge after Deductible

Office Surgery, including anesthesia, performed in and billed by the Practitioner's office Some procedures require Prior Authorization. Call Our consumer advisors to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, and services are Medically Necessary, benefits may be reduced to 40% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). If the reduction to 40% results in liability to the Member greater than $2,500 above what the Member would have paid had Prior Authorization been obtained, then the Member may contact customer service to have the claim reviewed and adjusted and the reduction will be limited to $2,500. (Services that are determined to not be Medically Necessary are not Covered.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization. Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services (e.g., non-screening colonoscopy, sigmoidoscopy and endoscopy).	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Non-routine treatments: Includes renal dialysis, radiation therapy, chemotherapy and infusions. Does not apply to Specialty Drugs. See Provider Administered Specialty Drugs section for applicable benefit.	100% after $45 Copayment	50% of the Maximum Allowable Charge after Deductible
Supplies	100%	50% of the Maximum Allowable Charge after Deductible
Services Received at a Facility		
Prior Authorization required for Inpatient Hospital stays (except maternity), Inpatient Behavioral Health Services, Skilled Nursing Facility or Rehabilitation Facility Stays and for certain Outpatient Facility procedures. Call Our consumer advisors to determine if Prior Authorization is required before receiving Outpatient Facility services. Benefits will be reduced to 40% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained and services are Medically Necessary. If the reduction to 40% results in liability to the Member greater than $2,500 above what the Member would have paid had Prior Authorization been obtained, then the		

Member may contact Our consumer advisors to have the claim reviewed and adjusted and the reduction will be limited to $2,500. (Services that are determined to not be Medically Necessary are not Covered.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.		
Inpatient Hospital Stays, including Behavioral Health Services, and maternity stays:		
Facility charges	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Practitioner charges (including global maternity delivery charges billed as inpatient service)	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Skilled Nursing or Rehabilitation Facility stays: (Limited to 60 days combined per Annual Benefit Period)		
Facility charges	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Practitioner charges	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Outpatient Facility Services **Outpatient Surgery** Surgeries include invasive diagnostic services (e.g., non-screening colonoscopy, sigmoidoscopy, and endoscopy).		
Facility charges	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Practitioner charges	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Other Outpatient procedures, services, or supplies		
Supplies	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Provider Administered Specialty Drugs	80% after Deductible	50% of the Maximum Allowable Charge after Deductible

All Other services received at an outpatient facility, including chemotherapy, radiation therapy, renal dialysis and sleep studies.	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Hospital Emergency Care services		
Emergency Room charges An observation stay that occurs in conjunction with an ER visit will be subject to member cost share under the Outpatient Facility Services section, above, in addition to member cost share for the ER visit.	100% after $500 Copayment	100% of the Maximum Allowable Charge after $500 Copayment
Advanced Radiological Imaging Services Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.	80% after Deductible	80% of the Maximum Allowable Charge after Deductible
All Other Hospital Charges	100%	100% of the Maximum Allowable Charge
Practitioner charges	100%	100% of the Maximum Allowable
Other Services (Any Place of Service)		
Advanced Radiological Imaging Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies. **Advanced Radiological Imaging services require Prior Authorization, except when performed as part of an Emergency Care visit**. If Prior Authorization is not obtained, and services are Medically Necessary, benefits may be reduced to 40% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). If the reduction to 40% results in liability to the Member greater than $2,500 above what the Member would have paid had Prior Authorization been obtained, then the Member may contact Our consumer advisors to have the claim reviewed and adjusted and the reduction will be limited to $2,500. (Services that are determined to not be Medically Necessary are not Covered.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.	80% after Deductible	50% of the Maximum Allowable Charge after Deductible

All Other Diagnostic Services for illness, injury or maternity care	100%	50% of the Maximum Allowable Charge after Deductible
Therapy Services: Physical, speech, occupational, and manipulative therapy limited to twenty (20) visits per therapy type per Annual Benefit Period; Cardiac and pulmonary rehab therapy limited to thirty-six (36) visits per therapy type per Annual Benefit Period An office visit Copayment may apply to evaluation and management claims filed by a therapy provider. Please refer to Practitioner Office Visits section of this schedule.	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Home Health Care Services, including home infusion therapy Prior Authorization is required for skilled nurse visits in the home, including those for home infusion therapy. Physical, speech, occupational or habilitative therapy provided in the home does not require Prior Authorization. Home Health Care is limited to sixty (60) visits per Annual Benefit Period	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Durable Medical Equipment, Orthotics and Prosthetics Prior Authorization may be required for certain Durable Medical Equipment, Orthotics, or Prosthetics	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Hearing Aids for Members under age eighteen (18) Limited to one (1) per ear every three (3) years (as determined by Your Annual Benefit Period)	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Ambulance	80% after Deductible	80% of the Maximum Allowable Charge after Deductible
Hospice Care	100%	50% of the Maximum Allowable Charge after Deductible
Organ Transplant Services		

Organ Transplant Services, all transplants except kidney All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Transplant Network Providers are different from Network Providers for other services. Call Our consumer advisors before any pre-transplant evaluation or other transplant service is performed to request Authorization, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may balance bill the Member for amounts over TMAC not Covered by the Plan.	**Transplant Network benefits:** 80% after Network Deductible, Network Out-of-Pocket Maximum applies.	**Network Providers not in Our Transplant Network (Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee):** 80% of Transplant Maximum Allowable Charge (TMAC) after Network Deductible; Network Out-of-Pocket applies. Amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not Covered.	**Out-of-Network Providers:** 50% of Maximum Allowable Charge (MAC), after Out-of-Network Deductible; Out-of-Pocket Maximum applies and amounts over MAC do not apply to the Out-of-Pocket and are not Covered.
Organ Transplant Services, kidney transplants All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Call Us at the number on the back of Your Member ID Card before any pre-transplant evaluation or other transplant service is performed to begin the Authorization process.	**Network Providers:** 80% after Network Deductible; Network Out-of-Pocket Maximum applies.	**Out-of-Network Providers:** 50% of Maximum Allowable Charge (MAC), after Out-of-Network Deductible; Out-of-Pocket Maximum applies and amounts over MAC do not apply to the Out-of-Pocket and are not Covered.	

Pharmacy Prescription Drug Program for retail and mail order Prescriptions			
Prescription Drugs [1, 2]	Generic Drug	Preferred Brand Drug	Non-Preferred Brand Drug[3]
Retail network up to a 30 day supply	$3	$45	$75
Mail Order Network and Select90 Network up to a 90 day supply Copay applies to each thirty (30) day supply	$3	$45	$75

Out-of-Network [4]	50% of the Maximum Allowable Charge after Deductible

Specialty Drugs - You have a distinct network for Specialty Drugs: the Preferred Specialty Pharmacy Network. To receive benefits for self-administered Specialty Drugs, You must use a Preferred Specialty Pharmacy Network Provider. (Please refer to Your EOC for information on benefits for Provider-Administered Specialty Drugs.)

Specialty Drugs are limited to a thirty (30) day supply per Prescription.

Specialty Drugs [1,2]	**Specialty Pharmacy Network**
Self-administered Specialty Drugs, as indicated on Our Specialty Drug list.	$200
Out-of-Network	Not Covered

Pediatric Dental

Covered Services	**Network Dentist**	**Out-of-Network Dentist**
Coverage A Diagnostic and Preventive Services; Exams; Cleanings; X-rays	100%	100% of the Maximum Allowable Charge
Coverage B Basic and Restorative Services; Basic Restorative; Basic Endodontics; Oral Surgery; Basic Periodontics	80%	80% of the Maximum Allowable Charge
Coverage C Major Restorative and Prosthodontic Services; Major Restorative; Major Endodontics; Major Periodontics; Implants	50%	50% of the Maximum Allowable Charge
Coverage D Medically Necessary Orthodontia for Members under age 19. Prior Authorization is required.	80% after Deductible	50% of the Maximum Allowable Charge after Deductible

Pediatric Vision		
Benefit	Network	Out-of-Network
Exam with Dilation as Necessary	$0 Copayment	60% of Maximum Allowable Charge
Contact Lens Fit and Follow-Up:		
(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)		
Standard Contact Lens Fit and Follow-Up:	$0 Copayment	60% of Maximum Allowable Charge
Premium Contact Lens Fit and Follow-Up:	$0 Copayment	60% of Maximum Allowable Charge
Frames:		
Designated available frame at provider location	100% Coverage for Provider designated frames	60% of Maximum Allowable Charge
Standard Lenses (Glass or Plastic)		
Single Vision		
Bifocal	$0 Copayment	60% of Maximum Allowable Charge
Trifocal	$0 Copayment	60% of Maximum Allowable Charge
Lenticular	$0 Copayment	60% of Maximum Allowable Charge
Standard Progressive Lens	$0 Copayment	60% of Maximum Allowable Charge
Lens Options:	$0 Copayment	60% of Maximum Allowable Charge
UV Treatment		
Tint (Fashion & Gradient & Glass-Grey)	$0 Copayment	60% of Maximum Allowable Charge
Standard Plastic Scratch Coating	$0 Copayment	60% of Maximum Allowable Charge
Standard Polycarbonate	$0 Copayment	60% of Maximum Allowable Charge
Photocromatic / Transitions Plastic	$0 Copayment	60% of Maximum Allowable Charge
	$0 Copayment	60% of Maximum Allowable Charge
Contact Lenses		
(Contact lens includes materials only)	100% Coverage for Provider designated contact lenses	
Extended Wear and Extended Wear Disposables		
Daily Wear / Disposables	Up to 6 months supply of monthly or 2 week disposable, single vision spherical or toric contact lenses	60% of Maximum Allowable Charge

	Up to 3 months supply of daily disposable, single vision spherical contact lenses	60% of Maximum Allowable Charge

	In-Network Services received from Network Providers	**Out-of-Network Services received from Out-of-Network Providers**
Deductible		
Individual	$2,000	$4,000
Family	$2,000 per Member, not to exceed $4,000 for all Covered Family Members.	$4,000 per Member, not to exceed $8,000 for all Covered Family Members.
Out-of-Pocket Maximum		
Individual	$4,000	$12,000
Family	$4,000 per Member, not to exceed $8,000 for all Covered Family Members	$12,000 per Member, not to exceed $24,000 for all Covered Family Members
Annual Benefit Period	January 1 - December 31	

1. If You or the prescribing physician choose a Non-Preferred Brand Drug when a Generic Drug equivalent is available, You will be financially responsible for the amount by which the cost of the Non-Preferred Brand Drug exceeds the Generic Drug cost plus the required Generic Drug Copayment.
2. Some products may be subject to Quantity Limits, Step Therapy, and Prior Authorizations specified by the Plan's P & T Committee.
3. If You have a Prescription filled at an Out-of-Network Pharmacy, You must pay all expenses and file a claim for reimbursement with Us. Reimbursement is based on the Maximum Allowable Charge, less any applicable Out-of-Network Deductible, Coinsurance, and/or Drug Copayment amount.

When services that require Prior Authorization are received from Out-of-Network Providers, and Network Providers outside Tennessee, You are responsible for obtaining Prior Authorization. Benefits may be reduced to 40% for Out-of-Network Providers and Network Providers outside Tennessee when Prior Authorization is not obtained.