South Carolina

A TO Z COATINGS & INSULATION I

Coverage Period: 01/01/2017 - 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: SINGLE-FAMILY | Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.SouthCarolinaBlues.com** or by calling **1-800-868-2500, Ext. 41010**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$2,000 single / $6,000 family for in-network providers. $4,000 single / $12,000 family for out-of-network providers. Doesn't apply to preventive care, drugs or in-network dr's office visits. Copays don't apply to the deductible. The in-network and out-of-network amounts don't apply to each other.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes; $5,000 single / $10,000 family for in-network providers. $10,000 single / $20,000 family for out-of-network providers. The in-network and out-of-network amounts don't apply to each other.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums; balance-billed charges; health care this plan doesn't cover and penalties for not obtaining preauthorization.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.SouthCarolinaBlues.com or call 1-800-810-2583	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed in the Excluded Services and Other Covered Services section. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-868-2500, Ext. 41010** or visit us at **www.SouthCarolinaBlues.com.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call **1-800-868-2500, Ext. 41010** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible.**
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-Of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	50% coinsurance	Does not include surgery, outpatient lab and X-ray services (except for standard plain film X-rays), second surgical opinion, dialysis, chemotherapy, radiation therapy, specialty drugs, endoscopies and imaging.
	Specialist visit	$40 copay/visit	50% coinsurance	Does not include surgery, outpatient lab and X-ray services (except for standard plain film X-rays), second surgical opinion, dialysis, chemotherapy, radiation therapy, specialty drugs, endoscopies and imaging.
	Other practitioner office visit	Not covered	Not covered	NONE
	Preventive care/screening/immunization	$0	Not covered	No charge for mammograms at a participating provider.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	NONE
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	No benefit if not preapproved.
If you need drugs to treat your illness or condition	Tier 1	$8 copay/prescription (retail) $16 copay/prescription (mail-order)	$8 copay/prescription (retail) then 50% coinsurance	Covers up to a 90-day, subject to 3 copays. Includes mail-order pharmacy.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-Of-Network Provider	Limitations & Exceptions
	Tier 2	$30 copay/prescription (retail) $70 copay/prescription (mail-order)	$30 copay/prescription (retail) then 50% coinsurance	Covers up to a 90-day, subject to 3 copays. Includes mail-order pharmacy.
	Tier 3	$60 copay/prescription (retail) $140 copay/prescription (mail-order)	$60 copay/prescription (retail) then 50% coinsurance	Covers up to a 90-day, subject to 3 copays. Includes mail-order pharmacy.
More information about **prescription drug coverage** is available at **www.SouthCarolinaBlues.com**	Tier 4	10% copay/prescription	Not covered	$200/dose maximum copay applies. Specialty Drug Network Provider Only, up to 31-day supply. No benefits if not preapproved.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	50% reduction of allowed amount if not preapproved for hysterectomy or septoplasty. Cosmetic surgery is not covered.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	50% reduction of allowed amount if not preapproved for hysterectomy or septoplasty. Cosmetic surgery is not covered.
If you need immediate medical attention	Emergency room services	30% coinsurance	Facility charges only - 30% coinsurance. All other charges - 50% coinsurance.	NONE
	Emergency medical transportation	30% coinsurance	50% coinsurance	NONE

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-Of-Network Provider	Limitations & Exceptions
	Urgent care	$20 copay/visit	50% coinsurance	Does not include surgery, outpatient lab and X-ray services (except for standard plain film X-rays), second surgical opinion, dialysis, chemotherapy, radiation therapy, specialty drugs, endoscopies and imaging.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Room and board denied if stay is not approved. No benefits for human organ/tissue transplant if not preapproved and at designated provider.
	Physician/surgeon fee	30% coinsurance	50% coinsurance	No benefits for human organ/tissue transplant if not preapproved and at designated provider.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% coinsurance	50% coinsurance	50% reduction of allowed amount if not preapproved. $20 copay/visit for in-network office visits.
	Mental/Behavioral health inpatient services	30% coinsurance	50% coinsurance	Room and board denied if stay is not approved.
	Substance use disorder outpatient services	30% coinsurance	50% coinsurance	50% reduction of allowed amount if not preapproved. $20 copay/visit for in-network office visits.
	Substance use disorder inpatient services	30% coinsurance	50% coinsurance	Room and board denied if stay is not approved.
If you are pregnant	Prenatal and postnatal care	30% coinsurance	50% coinsurance	For employee or spouse only. Covers screening for gestational diabetes and lactation support/counseling for dependent children.
	Delivery and all inpatient services	30% coinsurance	50% coinsurance	For employee or spouse only.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-Of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Limited to 60 visits/year. No benefits if not preapproved.
	Rehabilitation services	30% coinsurance	50% coinsurance	Outpatient physical, occupational and speech therapy limited to 30 visits/year combined. No inpatient benefits if not preapproved and at designated provider.
	Habilitation services	Not Covered	Not Covered	NONE
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 60 days/year. Room and board denied if stay is not approved.
	Durable medical equipment	30% coinsurance	Not covered	Excludes repair of, replacement of and duplicate. No benefits if not preapproved when cost is $500 or more.
	Hospice service	30% coinsurance	50% coinsurance	Limited to 6 months/episode. No benefits if not preapproved.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	NONE
	Glasses	Not covered	Not covered	NONE
	Dental check-up	Not covered	Not covered	NONE

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Eye exam (Child)
- Glasses (Child)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Other practitioner office visit
- Private duty nursing
- Residential and custodial care

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Routine eye care (Adult)
- Routine foot care
- Routine maternity for dependent child
- TMJ and related conditions
- Varicose veins treatment
- Weight loss programs

Other Covered Services. (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Non-emergency care when traveling outside the U.S. See www.SouthCarolinaBlues.com/members/findaprovider.aspx

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-868-2500, ext. 41010. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the plan at 1-800-868-2500, ext. 41000 or visit www.SouthCarolinaBlues.com, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, your state office of health insurance customer assistance at: 1-800-768-3467 or visit www.doi.sc.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage."**This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).**This health coverage does meet the minimum value standard for the benefits it provides.**

Spanish: Para obtener asistencia en español, llame al número de atención al cliente que aparece en la primera página de esta notificación.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $3,800**
- **Patient pays $3,740**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Co-pays	$10
Co-insurance	$1,580
Limits or exclusions	$150
Total	**$3,740**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $2,880**
- **Patient pays $2,520**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Co-pays	$340
Co-insurance	$100
Limits or exclusions	$80
Total	**$2,520**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697(TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات
الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190 . (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید.
(Persian-Farsi)