South Carolina

# FIRST COMMUNITY BANK : High Option

**Coverage Period: 01/01/2015 - 12/31/2015**

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

**Coverage for**: Individual | **Plan Type**: Standard 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 **1-800-760-9290**.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network **$500** person/**$1,000** family. Out-of-Network **$5,000** person/**$10,000** family. Doesn't apply to prescription drugs, inpatient facilty, ER facility & all MH/SU inpatient & ER services. | 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. In-Network **$6,600** person/**$13,200** family. Out-of-Network **$15,000** person/**$30,000** family. | 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 and health care this plan doesn't cover. Per Admission Copayments and Per Occurence Copayments do not apply towards the Out-of-Network Out-of-Pocket. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. See **www.SouthCarolinaBlues.com** or call **1-800-810-BLUE (2583)** for a list of participating providers. | 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 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 **1-800-760-9290** or visit us at www.SouthCarolinaBlues.com**.** If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call **1-800-760-9290** to request a copy.

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- **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 | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 Copay per visit | 50% Coinsurance | Allergy injections, second surgical opinions, dialysis, chemotherapy, and radiation are covered at 20% Coinsurance In-Network. |
| | Specialist visit | $60 Copay per visit | 50% Coinsurance | Allergy injections, second surgical opinions, dialysis, chemotherapy, and radiation are covered at 20% Coinsurance In-Network. |
| | Other practitioner office visit | $30 Copay per visit | 50% Coinsurance | Chiropractic services are limited to a $1,000 annual maximum. Chiropractic office visits and modalities are not covered. |
| | Preventive care/screening/immunization | No Charge | Not Covered | There may be additional benefits available. See your Employer for details. See www.healthcare.gov for preventive care guidelines. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% Coinsurance | 50% Coinsurance | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | 20% Coinsurance | 50% Coinsurance | Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges. |

| Common Medical Event | Services You May Need | Your cost if you use | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.SouthCarolinaBlues.com | Generic drugs (Retail) | $20 Copay per prescription | $20 Copay per prescription then 50% of remaining cost | 90 day supply. Copay applies to each 31 day supply. |
| | Generic drugs (Mail Order) | $40 Copay per prescription | Not Covered | 90 day supply. |
| | Preferred brand drugs (Retail) | $40 Copay per prescription | $40 Copay per prescription then 50% of remaining cost | 31 day supply. |
| | Preferred brand drugs (Mail Order) | $90 Copay per prescription | Not Covered | 90 day supply. |
| | Non-preferred brand drugs (Retail) | $70 Copay per prescription | $70 Copay per prescription then 50% of remaining cost | 31 day supply. |
| | Non-preferred brand drugs (Mail Order) | $175 Copay per prescription | Not Covered | 90 day supply. |
| | Specialty drugs | $125 Copay per prescription | Not Covered | 31 day supply. Available at Accredo Specialty Pharmacy only. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance | 50% Coinsurance | Pre-authorization is required for some outpatient surgeries. Penalty for not obtaining pre-authorization is 50% of the allowable charge. |
| | Physician/surgeon fees | 20% Coinsurance | 50% Coinsurance | ——————none—————— |
| **If you need immediate medical attention** | Emergency room services | $100 Copay per visit | $100 Copay per visit | Copayment will be waived if admitted. |

| Common Medical Event | Services You May Need | Your cost if you use | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| | Emergency medical transportation | 20% Coinsurance | 20% Coinsurance | ——————none—————— |
| | Urgent care | $60 Copay per visit | 50% Coinsurance | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% Coinsurance | $200 Copay per admission then 50% Coinsurance | Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board. |
| | Physician/surgeon fee | 20% Coinsurance | 50% Coinsurance | ——————none—————— |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 20% Coinsurance | 50% Coinsurance | Pre-authorization is required except office visits. Penalty for not obtaining pre-authorization is 50% of the allowable charge. Office visits are covered at a $30 copay per visit In-Network. |
| | Mental/Behavioral health inpatient services | 20% Coinsurance | 50% Coinsurance | Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board. |
| | Substance use disorder outpatient services | 20% Coinsurance | 50% Coinsurance | Pre-authorization is required except office visits. Penalty for not obtaining pre-authorization is 50% of the allowable charge. Office visits are covered at a $30 copay per visit In-Network. |
| | Substance use disorder inpatient services | 20% Coinsurance | 50% Coinsurance | Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board. |
| **If you are pregnant** | Prenatal and postnatal care | $30 Copay per visit | 50% Coinsurance | No additional copayment for ongoing routine care. |
| | Delivery and all inpatient services | 20% Coinsurance | $200 Copay per admission then 50% Coinsurance | Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board. |

| Common Medical Event | Services You May Need | Your cost if you use | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| **If you need help recovering or have other special health needs** | Home health care | 20% Coinsurance | 50% Coinsurance | Limited to 60 visits per benefit year. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges. |
| | Rehabilitation services | 20% Coinsurance | 50% Coinsurance | Occupational Therapy & Physical Therapy limited to a combined 30 visits per benefit year. Speech Therapy limited to 20 visits per benefit year. Limitations are combined with Habilitation services. |
| | Habilitation services | 20% Coinsurance | 50% Coinsurance | Occupational Therapy & Physical Therapy limited to a combined 30 visits per benefit year. Speech Therapy limited to 20 visits per benefit year. Limitations are combined with Rehabilitation services. |
| | Skilled nursing care | 20% Coinsurance | $200 Copay per admission then 50% Coinsurance | Limited to 60 days per benefit year. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board. |
| | Durable medical equipment | 20% Coinsurance | Not Covered | Purchase or rentals of $500 or more require pre-authorization. Penalty for not obtaining pre-authorization is denial of all charges. |
| | Hospice service | 20% Coinsurance | 50% Coinsurance | Limited to 6 months per episode. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges. |
| **If your child needs dental or eye care** | Eye exam | Not Covered | Not Covered | See your Employer for benefit details. |
| | Glasses | Not Covered | Not Covered | See your Employer for benefit details. |
| | Dental check-up | Not Covered | Not Covered | See your Employer for benefit details. |

## 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
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Child)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Routine Eye Care (Adult)
- Routine Eye Care (Child)
- Routine Foot Care
- 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.)**

- Chiropractic Care
- Most coverage provided outside the U.S. See www.SouthCarolinaBlues.com
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing, if part of pre-authorized home health care

## 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 1-800-760-9290. 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 any or all of the following:

- 1-800-760-9290 or visit us at www.SouthCarolinaBlues.com
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
- The South Carolina State Department of Insurance at 1-800-768-3467 or visit www.doi.sc.gov

## Language Access Services:

To obtain assistance in your specific language, call the customer service number shown on the first page of this notice.
Spanish: Para obtener asistencia en español, llame al número de atención al cliente que aparece en la primera página de esta notificación.
Tagalog: Upang makakuha ng tulong sa Tagalog, tawagan ang numero ng *customer service* na makikita sa unang pahina ng paunawang ito.
Chinese: 如需中文服务，请致电列于本通知首页的客户服务号码。

Navajo: T'áá Dinéjí shił hane'go shíká i'doolwoł ninízingo éí Nidaalnishígíí Áká Anídaalwo'ígíí, customer service, bich'į' hodíilnih. Bik'ehgo bich'į' hane'ígíí éí díí naaltsoos neiyi'nilígíí akáa'gi siłtsoozígíí bikáá' ííshjáąh.

———————————*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 $5,800**
- **Patient pays $1,740**

**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 | $500 |
| Copays | $80 |
| Coinsurance | $1,010 |
| Limits or exclusions | $150 |
| **Total** | **$1,740** |

These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-800-760-9290.

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,550**
- **Patient pays $1,850**

**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 | $500 |
| Copays | $1,050 |
| Coinsurance | $220 |
| Limits or exclusions | $80 |
| **Total** | **$1,850** |

# 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.

**Questions:** Call **1-800-760-9290** or visit us at www.SouthCarolinaBlues.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call **1-800-760-9290** to request a copy.