



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

Coverage for: SINGLE-FAMILY | Plan Type: HDHP



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?	\$5,000 single/\$10,000 family; Doesn't apply to preventive care, and office visit charges and prescription drugs when a copay applies. Deductible doesn't include Copays.	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 Preferred Blue® Providers. For all other providers \$10,000 single/\$20,000 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?	Copayments; premiums; balance-billed charges; health care this plan doesn't cover; and penalties for failure to obtain preauthorization for services	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 Preferred Blue providers, see www.SouthCarolinaBlues.com or call 1-800-868-2500, ext. 41000.	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 do not 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		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35 copay/visit	40% coinsurance	0% coinsurance for in-network office services such as: surgery, second surgical opinion, consultations, dialysis treatment, chemotherapy, radiation therapy, specialty drugs, endoscopies and imaging. Deductible does not apply if copay applies.
	Specialist visit	\$60 copay/visit	40% coinsurance	0% coinsurance for in-network office services such as: surgery, second surgical opinion, consultations, dialysis treatment, chemotherapy, radiation therapy, specialty drugs, endoscopies and imaging. Deductible does not apply if copay applies.
	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)	0% coinsurance	40% coinsurance	NONE
	Imaging (CT/PET scans, MRIs)	0% coinsurance	40% coinsurance	No benefit if not preapproved.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <u>www.SouthCarolinaBlues.com</u>	Generic drugs	\$8 copay/prescription (retail) \$16 copay/prescription (mail order)	\$8 copay/prescription (retail) and 40% coinsurance	Covers up to a 31-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	\$30 copay/prescription (retail) \$70 copay/prescription (mail order)	\$30 copay/prescription (retail) and 40% coinsurance	Covers up to a 31-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Non-preferred brand drugs	\$60 copay/prescription (retail) \$140 copay/prescription (mail order)	\$60 copay/prescription (retail) and 40% coinsurance	Covers up to a 31-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Specialty drugs	10% copay/prescription (mail order)	Not covered	Covers up to a 31-day mail order supply at a Specialty Drug Network Provider. No benefits if not preapproved. \$200/dose maximum copay.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	40% coinsurance	50% reduction of allowed amount if not preapproved for hysterectomy or septoplasty.
	Physician/surgeon fees	0% coinsurance	40% coinsurance	50% reduction of allowed amount if not preapproved for hysterectomy or septoplasty.
If you need immediate medical attention	Emergency room services	0% coinsurance	Facility charges only - 0% coinsurance. All other charges - 40% coinsurance.	NONE
	Emergency medical transportation	0% coinsurance	40% coinsurance	NONE

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Urgent care	\$35 /\$60 copay/visit	40% coinsurance	0% coinsurance for in-network office services such as: surgery, second surgical opinion, consultations, dialysis treatment, chemotherapy, radiation therapy, specialty drugs, endoscopies and imaging. Deductible does not apply if copay applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	40% 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	0% coinsurance	40% 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	0% coinsurance	40% coinsurance	50% reduction of allowed amount if not preapproved. Limited to 25 outpatient/office visits per year for mental/behavioral and substance use combined.
	Mental/Behavioral health inpatient services	0% coinsurance	40% coinsurance	Room and board denied if stay is not approved. Limited to 7 days per year for mental/behavioral and substance use combined.
	Substance use disorder outpatient services	0% coinsurance	40% coinsurance	50% reduction of allowed amount if not preapproved. Limited to 25 outpatient/office visits per year for mental/behavioral and substance use combined.
	Substance use disorder inpatient services	0% coinsurance	40% coinsurance	Room and board denied if stay is not approved. Limited to 7 days per year for mental/behavioral and substance use combined.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you are pregnant	Prenatal and postnatal care	0% coinsurance	40% coinsurance	For employee or spouse only. Covers screening for gestational diabetes and lactation support/counseling for dependent children.
	Delivery and all inpatient services	0% coinsurance	40% coinsurance	For employee or spouse only.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance	Limited to 60 visits/year. No benefits if not preapproved.
	Rehabilitation services	0% coinsurance	40% coinsurance	No inpatient benefits if not preapproved and at designated provider. Outpatient/office physical therapy limited to 30 visits per year (speech/occupational therapy not covered).
	Habilitation services	Not covered	Not covered	NONE
	Skilled nursing care	0% coinsurance	40% coinsurance	Limited to 60 days/year. Room and board denied if not approved.
	Durable medical equipment	0% coinsurance	Not covered	Excludes repair of, replacement of and duplicate. No benefits if not preapproved when cost is \$500 or more. Prosthetics is limited to \$50,000/year.
	Hospice service	0% coinsurance	40% 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
- Cosmetic surgery
- Eye exam (Child)
- Hearing aids
- Other practitioner office visit
- Routine eye care (Adult)
- TMJ and related conditions
- Bariatric surgery
- Dental care (Adult)
- Glasses (Child)
- Infertility treatment
- Private duty nursing
- Routine foot care
- Varicose veins treatment
- Chiropractic care
- Dental care (Child)
- Habilitation services
- Long-term care
- Residential and custodial care
- Routine maternity for dependent child
- 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
- Prescription drug (preferred, non-preferred and specialty drugs)

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 \$2,390
- Patient pays \$5,150

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	\$5,000
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$5,150

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

- Amount owed to providers: \$5,400
- Plan pays \$2,580
- Patient pays \$2,820

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	\$2,420
Co-pays	\$320
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$2,820

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 1-800-868-2500, 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. BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

