**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-868-2500, Ext. 41010 to request a copy. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-800-868-2500, Ext. 41010 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | $1,500 single / $4,500 family for in-network providers. $3,000 single / $9,000 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. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care services and office visits are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services. |
| **What is the maximum out-of-pocket limit for this plan?** | Yes; $4,500 single / $9,000 family for in-network providers. $9,000 single / $18,000 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 in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the maximum out-of-pocket limit?** | Premiums; charges in excess of the allowed amount; amounts exceeding any maximum payments for benefits; or any expense not allowed according to any provisions of this coverage. | Even though you pay these expenses, they don't count toward the maximum out-of-pocket limit. |

| | | |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. For a list of in-network providers, see https://www.SouthCarolinaBlues.com/links/tools/findadoctorsc or call 1-800-810-2583 | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **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 a referral. |

⚠ All **copayments** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations , Exceptions & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-Of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 copay/visit | 40% coinsurance | Copay doesn't include surgery, outpatient lab and X-ray services (except for standard plain film X-rays), second surgical opinion, dialysis, chemotherapy, radiation therapy, administration of specialty drugs, endoscopies and imaging. |
| | Specialist visit | $40 copay/visit | 40% coinsurance | Copay doesn't include surgery, outpatient lab and X-ray services (except for standard plain film X-rays), second surgical opinion, dialysis, chemotherapy, radiation therapy, administration of specialty drugs, endoscopies and imaging. |
| | Preventive care/screening/immunization | No charge | Not covered | No charge for mammograms at a participating provider. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | NONE |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | No benefit if not preapproved. |
| **If you need drugs to treat your illness or condition** | Tier 1 Drugs | $8 copay/prescription (retail) $16 copay/prescription (mail-order) | $8 copay/prescription (retail) then 40% coinsurance | Covers up to a 90-day, subject to 3 copays. Includes mail-order pharmacy. |
| | Tier 2 Drugs | $30 copay/prescription (retail) $70 copay/prescription (mail-order) | $30 copay/prescription (retail) then 40% coinsurance | Covers up to a 90-day, subject to 3 copays. Includes mail-order pharmacy. |
| | Tier 3 Drugs | $60 copay/prescription (retail) $140 copay/prescription (mail-order) | $60 copay/prescription (retail) then 40% coinsurance | Covers up to a 90-day, subject to 3 copays. Includes mail-order pharmacy. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations , Exceptions & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-Of-Network Provider (You will pay the most) | |
| More information about **prescription drug coverage** is available at **www.SouthCarolinaBlues.com/links/metallic/pharmacy/BusinessBlueEssentials** | Tier 4 Drugs | 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) | 20% coinsurance | 40% coinsurance | 50% reduction of allowed amount if preapproval is required and not obtained. Cosmetic surgery is not covered. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | 50% reduction of allowed amount if preapproval is required and not obtained. Cosmetic surgery is not covered. |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | Facility charges only - 20% coinsurance. All other charges - 40% coinsurance | NONE |
| | Emergency medical transportation | 20% coinsurance | 40% coinsurance | NONE |
| | Urgent care | $20 copay/visit | 40% coinsurance | Copay doesn't include surgery, outpatient lab and X-ray services (except for standard plain film X-rays), second surgical opinion, dialysis, chemotherapy, radiation therapy, administration of specialty drugs, endoscopies and imaging. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% 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 | 20% coinsurance | 40% coinsurance | No benefits for human organ/tissue transplant if not preapproved and at designated provider. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations , Exceptions & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-Of-Network Provider (You will pay the most) | |
| **If you have mental health, behavioral health, or substance abuse needs** | Outpatient services | 20% coinsurance | 40% coinsurance | $20 copay/visit for in-network office visit. 50% reduction of allowed amount if not preapproved. |
| | Inpatient services | 20% coinsurance | 40% coinsurance | Room and board denied if stay is not approved. |
| **If you are pregnant** | Office Visits | $20 copay/visit | 40% coinsurance | Copay doesn't include surgery, outpatient lab and X-ray services (except for standard plain film X-rays), second surgical opinion, dialysis, chemotherapy, radiation therapy, administration of specialty drugs, endoscopies and imaging. |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | For employee or spouse only. Covers screening for gestational diabetes and lactation support for dependent children. |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | For employee or spouse only. |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | Limited to 60 visits/year. No benefits if not preapproved. |
| | Rehabilitation services | 20% coinsurance | 40% 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 | 20% coinsurance | 40% coinsurance | Limited to 60 days/year. Room and board denied if stay is not approved. |
| | Durable medical equipment | 20% coinsurance | Not covered | Excludes repair of, replacement of and duplicate. No benefits if not preapproved when cost is $500 or more. |
| | Hospice service | 20% coinsurance | 40% coinsurance | Limited to 6 months/episode. No benefits if not preapproved. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations , Exceptions & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-Of-Network Provider (You will pay the most) | |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | NONE |
| | Children's glasses | Not covered | Not covered | NONE |
| | Children's dental check-up | Not covered | Not covered | NONE |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Abortion*
- 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
- Private duty nursing
- Residential and custodial care
- 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. (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

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

## Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The State Insurance Department, 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. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit http://www.HealthCare.gov or call 1-800-318-2596.

## Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the plan at 1-800-868-2500, Ext. 41010 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? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

## Does this Coverage Meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*For more information about limitations and exceptions, see the plan or policy document at www.SouthCarolinaBlues.com.

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

# About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

## Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

**This EXAMPLE event includes services like:**
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

| **Total Example Cost** | **$12,700** |
|---|---|

In this example, Peg would pay:

| Cost Sharing | |
|---|---|
| Deductibles | $1,500 |
| Copayments | $70 |
| Coinsurance | $2,500 |
| **What isn't covered** | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,130** |

## Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

**This EXAMPLE event includes services like:**
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

| **Total Example Cost** | **$7,400** |
|---|---|

In this example, Joe would pay:

| Cost Sharing | |
|---|---|
| Deductibles | $100 |
| Copayments | $1,200 |
| Coinsurance | $30 |
| **What isn't covered** | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$1,390** |

## Mia's Simple Fracture (in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

**This EXAMPLE event includes services like:**
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

| **Total Example Cost** | **$1,900** |
|---|---|

In this example, Mia would pay:

| Cost Sharing | |
|---|---|
| Deductibles | $1,300 |
| Copayments | $100 |
| Coinsurance | $300 |
| **What isn't covered** | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,700** |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

## 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@hrcompliance.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).

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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)

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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 [在此插入数字 1-844-396-0188。 (Chinese)

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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)

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

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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)

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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)

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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)

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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)

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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)

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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)

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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)

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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)

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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)

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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)

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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)

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