



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 1-800-868-2528 or visit us at [www.BlueChoiceSC.com](http://www.BlueChoiceSC.com). 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 <https://www.healthcare.gov/sbc-glossary> or call 1-800-868-2528 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	\$1,000/Individual/\$2,000/family for in-network; \$2,500/Individual/\$5,000/family for out-of-network	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	<u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$5,000/Individual/\$10,000/family for in-network <u>providers</u> . \$10,500/Individual/\$21,000/family for out-of-network.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.BlueChoiceSC.com">www.BlueChoiceSC.com</a> or call 1-800-868-2528 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a referral.



All copayment and coinsurance costs shown in this chart are after your overall 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	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$60 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge for covered services	Not covered	None
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	<u>Imaging</u> (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If you need drugs to treat your illness or condition	Tier 1	\$8.00 <u>copay</u> /retail prescription; \$20.00 <u>copay</u> /mail order prescription;	Not covered	You will have to pay more if you select a non-generic drug instead of its less expensive Covered generic drug (or Covered over-the-counter alternative). <u>Deductible</u> does not apply
	Tier 2	\$25.00 <u>copay</u> /retail prescription; \$62.50 <u>copay</u> /mail order prescription		
	Tier 3	\$45.00 <u>copay</u> /retail prescription; \$112.50 <u>copay</u> /mail order prescription	Not covered	You will have to pay more if you select a non-generic drug instead of its less expensive Covered generic drug (or Covered over-the-counter alternative). <u>Deductible</u> does not apply
	Tier 4	\$70.00 <u>copay</u> /retail prescription; \$175.00 <u>copay</u> /mail order prescription	Not covered	You will have to pay more if you select a non-generic drug instead of its less expensive Covered generic drug (or Covered over-the-counter alternative). <u>Deductible</u> does not apply

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 <b>prescription drug coverage</b> is available at <a href="http://www.BlueChoiceSC.com/CDL">www.BlueChoiceSC.com/CDL</a>	Tier 5  Tier 6	\$125.00 <u>copay</u> /retail prescription; \$312.50 <u>copay</u> /mail order prescription; \$175.00 <u>copay</u> /retail prescription; \$437.50 <u>copay</u> /mail order prescription	Not covered	<u>Specialty</u> medications are not available through the mail order program for a 90-day supply. This only applies to generic or brand drugs in these tiers. Not Covered: Drugs designated as excluded on the Prescription Drug List. <u>Deductible</u> does not apply
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. Ambulatory Surgery Center covered at \$60 <u>copay</u> /visit; <u>deductible</u> does not apply
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. Ambulatory Surgery Center covered at \$60 <u>copay</u> /visit; <u>deductible</u> does not apply
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$250 <u>copay</u> /visit then 30% <u>coinsurance</u> ; <u>deductible</u> does not apply	\$250 <u>copay</u> /visit, 30% <u>coinsurance</u> ; <u>deductible</u> does not apply	None
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$60 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Must be at a participating <u>Urgent Care provider</u> .
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
<b>If you have mental health, behavioral health, or substance abuse needs</b>	<u>Outpatient</u> services	\$30 <u>copay</u> /office visit and 30% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	<u>Preauthorization</u> is required for certain services.

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)	
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required for certain services.
If you are pregnant	Office visits	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior <u>authorization</u> required No additional co-pay for ongoing routine care Home births are not covered
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior <u>authorization</u> required No additional co-pay for ongoing routine care Home births are not covered
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior <u>authorization</u> required No additional co-pay for ongoing routine care Home births are not covered
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required; 20 visits each/year. Includes physical therapy, speech therapy and occupational therapy.
	<u>Habilitation services</u>	Not covered	Not covered	None
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required; 120 days/year
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required; initial device only
	<u>Hospice service</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required

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	\$0 / exam for eyeglasses every Benefit Period \$45 / exam for contact lens fitting every Benefit Period	Not covered	For Members outside of the South Carolina service area, \$71 will be allowed toward the routine eye exam and a \$120 credit will apply to the purchase of eyewear. Claims must be filed by the Member.
	Children's glasses	No charge (every other benefit period)	Not covered	Coverage limited to one pair of glasses/year.
	Children's dental check-up	Not covered	Not covered	None

### Excluded Services & Other Covered Services:

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

- Acupuncture
- Hearing aids
- Weight loss programs
- Chiropractic care
- Bariatric Surgery
- Long-term care
- Dental Care (Adult)
- Cosmetic Surgery
- Routine foot care (Adult)
- Infertility treatment

**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.
- Routine eye care (Adult)
- Private Duty Nursing

### 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](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: BlueChoice HealthPlan at 1-800-868-2528 or visit [www.BlueChoiceSC.com](http://www.BlueChoiceSC.com), the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the South Carolina Department of Insurance, Consumer Services Division, Post Office Box 100105, Columbia, SC 29202-3105, telephone: 803-737-6180, Email: [consumers@doi.sc.gov](mailto:consumers@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.

## **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-868-2528

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-868-2528

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-868-2528

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-868-2528

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

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## 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 \$1,000
- Specialist Copayment \$60
- Hospital (facility) Coinsurance 30%
- Other Coinsurance 30%

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

#### *Cost Sharing*

Deductibles	\$1,000
Copayments	\$1,000
Coinsurance	\$3,000

#### *What isn't covered*

Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,060</b>

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

- The plan's overall deductible \$1,000
- Specialist Copayment \$60
- Hospital (facility) Coinsurance 30%
- Other Coinsurance 30%

**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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

#### *Cost Sharing*

Deductibles	\$1,000
Copayments	\$1,700
Coinsurance	\$600

#### *What isn't covered*

Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3,360</b>

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

- The plan's overall deductible \$1,000
- Specialist Copayment \$60
- Hospital (facility) Coinsurance 30%
- Other Coinsurance 30%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

#### *Cost Sharing*

Deductibles	\$800
Copayments	\$200
Coinsurance	\$500

#### *What isn't covered*

Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,500</b>

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [www.BlueChoiceSC.com](http://www.BlueChoiceSC.com) or by calling 1-800-868-2528.

\*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs on these EXAMPLE coverage 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](mailto: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 [在此插入數字 1-844-396-0183]。(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 đỡ 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 건보협에 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 تساعد 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 باره ی این برنامه ی 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 شماره ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

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