BlueChoice HealthPlan South Carolina

Business Advantage Gold 1502

Coverage Period: 01/01/2020 - 12/31/2020

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage for: INDIVIDUAL/FAMILY | Plan Type: PPO

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. 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:
What is the overall deductible?	$1,500 Individual / $3,000 Family for in-network.	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. See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services 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 out–of–pocket limit for this plan?	For network providers, $5,000 Individual / $10,000 Family	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 out-of-pocket limit?	Premiums, balance-billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See www.BlueChoiceSC.com or call 1-800-868-2528 for a list of network providers.	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 you need a referral to see a specialist?	No	You can see the **specialist** you choose without a referral.

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⚠ 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	$15 copay/office visit; deductible does not apply	50% coinsurance	None
	Specialist visit	$45 copay/office visit; deductible does not apply	50% coinsurance	None
	Preventive care/screening/immunization	No charge for covered services	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then, check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	Preauthorization is required
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Preauthorization is required
If you need drugs to treat your illness or condition	Tier 1	$15 copay/retail prescription; $30 copay/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). Deductible does not apply
	Tier 2	$15 copay/retail prescription; $30 copay/mail order prescription		
	Tier 3	$35 copay/retail prescription; $70 copay/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). Deductible 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)	
	Tier 4	$70 copay/retail prescription; $140 copay/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). Deductible does not apply
More information about **prescription drug coverage** is available at **www.BlueChoiceSC.com/CDL**	Tier 5	$250 copay/retail prescription; $500 copay/mail order prescription.	Not Covered	Specialty 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. Deductible does not apply.
	Tier 6	$250 copay/retail prescription; $500 copay/mail order prescription.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Preauthorization is required. Freestanding Ambulatory Surgery Center covered at $200 copay/visit; deductible does not apply.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Preauthorization is required
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance (Plus any amount above the allowable charge up to the billed amount.)	(In order to be covered, Emergency Room Services must be for an Emergency Medical Condition.)
	Emergency medical transportation	30% coinsurance	50% coinsurance	None
	Urgent care	$75 copay/visit; deductible does not apply	50% coinsurance	Must be at a participating Urgent Care 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 a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Preauthorization is required
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/office visit and 30% coinsurance for other outpatient service	50% coinsurance	Preauthorization is required for certain services.
	Inpatient services	30% coinsurance	50% coinsurance	Preauthorization is required for certain services.
If you are pregnant	Office visits	$45 copay/office visit; deductible does not apply	50% coinsurance	Preauthorization is required. No additional copay for ongoing routine care. Home births are not covered.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	Preauthorization is required. No additional copay for ongoing routine care. Home births are not covered.
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	Preauthorization is required. No additional copay for ongoing routine care. Home births are not covered.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Preauthorization is required. 60 visits per Benefit Period.
	Rehabilitation services	30% coinsurance	50% coinsurance	Preauthorization is required. 30 visits each/year includes occupational therapy, physical therapy and speech therapy
	Habilitation services	30% coinsurance	50% coinsurance	Preauthorization is required. 30 visits per Benefit Period
	Skilled nursing care	30% coinsurance	50% coinsurance	Preauthorization is required. 60 days per Benefit Period
	Durable medical equipment	30% coinsurance	50% coinsurance	Preauthorization is required. Up to purchase price.

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)	
	Hospice services	30% coinsurance	50% coinsurance	Preauthorization required. 6 months per episode.
If your child needs dental or eye care	Children's eye exam	$25	Not Covered	One comprehensive vision exam per Calendar year. Refer to your plan document for a full list of limits/exceptions.
	Children's glasses	$50	Not Covered	One pair of glasses (lenses and frames) from a designated selection perCalendar year. Refer to your plan document for a full list of limits/e xceptions.
	Children's dental check-up	Balance over $50	Balance over $50	No dental network

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
- Bariatric Surgery
- Cosmetic Surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Private Duty Nursing
- Routine foot care (adult)
- Weight loss programs.

Other Covered Services.(Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Dental Care (Adult)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)

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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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.

Does this plan 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, kwiijigo holne' 1-800-868-2528

——————————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** **$45**
- **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)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$1,500
Copayments	$0
Coinsurance	$3,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

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** **$45**
- **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)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$90
Copayments	$1,600
Coinsurance	$40
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,790**

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

- **The plan's overall deductible** **$1,500**
- **Specialist Copayment** **$45**
- **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)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$100
Coinsurance	$500
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 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 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 [在此插入数字 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)