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

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 https://www.healthcare.gov/sbc-glossary or call 1-800-868-2500, ext. 41010 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$4,000 single / $12,000 family** for in-network providers. **$8,000 single / $24,000 family** for out-of-network providers. Doesn't apply to preventive care, prescription drugs or in-network doctor's office visits (if copay applies). Copayments do not apply towards the deductible. The in-network and out-of-network amounts don't apply to each other.	Generally, you must pay all 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; **$8,500 single / $17,000 family** for in-network providers. **$17,000 single / $34,000** family for out-of-network providers. The in-network and out-of-network amounts don't apply to each other.	The maximum 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 maximum out-of-pocket limits until the overall family maximum out-of-pocket limit has been met.
What is not included in the maximum out–of–pocket limit?	Copayments on certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	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/providers/PreferredBlue 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 can see the specialist you choose without a referral.

All **copayment** 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	$30 copay/visit	40% coinsurance	All office charges for the treatment of illness, accident or injury with the exception of diagnostic services such as MRIs, MRAs, PET Scans, CT Scans, and other diagnostic scans
	Specialist visit	$50 copay/visit	40% coinsurance	
	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 More information about **prescription drug coverage** is available at www.southcarolinablues.com/links/pharmacy/Chamber51	Tier 1 Drugs	$8 copay/prescription (retail) $16 copay/prescription (mail-order)	$8 copay/prescription (retail) then 40% coinsurance	Quantity limits may apply. Some drugs may require prior approval. No benefits if not approved. Drugs that are considered specialty drugs must be purchased from our Specialty Pharmacy, Optum® Specialty Pharmacy.
	Tier 2 Drugs	$35 copay/prescription (retail) $80.50 copay/prescription (mail-order)	$35 copay/prescription (retail) then 40% coinsurance	
	Tier 3 Drugs	$70 copay/prescription (retail) $161 copay/prescription (mail-order)	$70 copay/prescription (retail) then 40% coinsurance	
	Tier 4 Drugs	20% up to $500 copay/prescription	Not covered	
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	

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

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 need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	NONE
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$50 copay/visit	40% coinsurance	All office charges for the treatment of illness, accident or injury with the exception of diagnostic services such as MRIs, MRAs, PET Scans, CT Scans, and other diagnostic scans
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.
If you have mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	$30 copay/visit for in-network office visits. 50% reduction of allowed amount if not preapproved.
	Inpatient services	20% coinsurance	40% coinsurance	Room and board denied if stay is not approved.

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

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 are pregnant	Office visits	$30 copay/visit	40% coinsurance	All office charges for the treatment of illness, accident or injury with the exception of diagnostic services such as MRIs, MRAs, PET Scans, CT Scans, and other diagnostic scans
	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	Physical, occupational and speech therapy limited to 30 Rehabilitative visits/year combined. No inpatient benefits if not preapproved.
	Habilitation services	20% coinsurance	40% coinsurance	Physical, occupational and speech therapy limited to 30 Habilitative visits/year combined. No inpatient benefits if not preapproved.
	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.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	NONE
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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

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.)			
• Acupuncture	• Dental care (Child)	• Infertility treatment	• Routine eye care (Adult)
• Bariatric surgery	• Eye exam (Child)	• Long-term care	• Routine foot care
• Cosmetic surgery	• Glasses (Child)	• Private duty nursing	• Routine maternity for dependent child
• Dental care (Adult)	• Hearing aids	• Residential and custodial care	• 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 (if purchased separately)

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 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 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 http://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 plan Provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan 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.

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	**$4,000**
Specialist copayment	**$50**
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*	$4,000
Copayments	$0
Coinsurance	$650
What isn't covered	
Limits or exclusions	$150
The total Peg would pay is	**$4,800**

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

The plan's overall deductible	**$4,000**
Specialist copayment	**$50**
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$2,430
Copayments	$0
Coinsurance	$570
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$3,080**

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

The plan's overall deductible	**$4,000**
Specialist copayment	**$50**
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$123
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Mia would pay is	**$173**

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