



**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:
<b>What is the overall deductible?</b>	\$2,600 single/\$5,200 family; Doesn't apply to preventive care.	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> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Preventive care services and office visits are covered before you meet your deductible.	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 deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the maximum out-of-pocket limit for this plan?</b>	Yes; \$2,600 single/ \$5,200 family for Preferred Blue® Providers. For all other providers \$5,200 single/ \$10,400 family.	The <u>maximum 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>maximum out-of-pocket limits</u> until the overall family <u>maximum out-of-pocket limit</u> has been met.
<b>What is not included in the maximum out-of-pocket limit?</b>	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 <u>maximum out-of-pocket limit</u> .



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<p><b>Will you pay less if you use a <u>network provider</u>?</b></p>	<p>Yes. For a list of Preferred Blue providers, see <a href="http://www.SouthCarolinaBlues.com">www.SouthCarolinaBlues.com</a> or call 1-800-868-2500, ext. 41000.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's 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 <u>provider's</u> 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.</p>
<p><b>Do I need a <u>referral</u> to see a <u>specialist</u>?</b></p>	<p>No. You do not need a referral to see a specialist.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>



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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	0% coinsurance	40% coinsurance	NONE
	Specialist visit	0% coinsurance	40% coinsurance	NONE
	Preventive care/screening/immunization	No charge	Not covered	No charge for mammograms at a participating provider.
<b>If you have a test</b>	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.
<b>If you need drugs to treat your illness or condition</b>	Tier 1 Drugs	0% coinsurance	40% coinsurance	Covers up to a 31-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Tier 2 Drugs	0% coinsurance	40% coinsurance	Covers up to a 31-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Tier 3 Drugs	0% coinsurance	40% coinsurance	Covers up to a 31-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Tier 4 Drugs	0% coinsurance	Not covered	Covers up to a 31-day mail order supply at a Specialty Drug Network Provider. No benefits if not preapproved.
More information about <b>prescription drug coverage</b> is available at <a href="http://www.southcarolinablues.com/links/legacy/pharmacy/smallgroup">www.southcarolinablues.com/links/legacy/pharmacy/smallgroup</a>				
<b>If you have outpatient surgery</b>	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.

\*For more information about limitations and exceptions, see the plan or policy document at [www.SouthCarolinaBlues.com](http://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	<u>Emergency room care</u>	0% coinsurance	Facility charges only - 0% coinsurance. All other charges-40% coinsurance.	NONE
	<u>Emergency medical transportation</u>	0% coinsurance	40% coinsurance	NONE
	<u>Urgent care</u>	0% coinsurance	40% coinsurance	NONE
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 services	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.
	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.
If you are pregnant	Office Visits	0% coinsurance	40% coinsurance	For employee or spouse only. Cover screening for gestational diabetes and lactation support/counseling for dependent children.
	Childbirth/delivery professional services	0% coinsurance	40% coinsurance	For employee or spouse only. Cover screening for gestational diabetes and lactation support/counseling for dependent children.
	Childbirth/delivery facility services	0% coinsurance	40% coinsurance	For employee or spouse only.

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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	0% coinsurance	40% coinsurance	Limited to 60 visits/year. No benefits if not preapproved.
	<u>Rehabilitation services</u>	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).
	<u>Habilitation services</u>	Not covered	Not covered	NONE
	<u>Skilled nursing care</u>	0% coinsurance	40% coinsurance	Limited to 60 days per year. Room and board denied if stay is not approved.
	<u>Durable medical equipment</u>	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.
	<u>Hospice service</u>	0% coinsurance	40% coinsurance	Limited to 6 months/episode. No benefits if not preapproved.
<b>If your child needs dental or eye care</b>	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 Generally 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
- Other practitioner office visit
- 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

\*For more information about limitations and exceptions, see the plan or policy document at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).

## 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.)**

- Weight loss programs

\*Abortion services (except in cases of rape, incest, or when the life of the mother is endangered)

**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](http://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](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 <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 on how 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 <https://www.dol.gov/agencies/ebsa>, your state office of health insurance customer assistance at: 1-800-768-3467 or visit [www.doi.sc.gov](http://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.\_\_\_\_\_

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 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 <u>plan's</u> overall <u>deductible</u>	\$2,600
■ <u>Specialist coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	0%
■ <u>Other coinsurance</u>	0%

**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	
<u>Deductibles*</u>	\$2,600
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,660</b>

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,600
■ <u>Specialist coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	0%
■ <u>Other coinsurance</u>	0%

**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>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles*</u>	\$2,600
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,620</b>

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,600
■ <u>Specialist coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	0%
■ <u>Other coinsurance</u>	0%

**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>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles*</u>	\$2,600
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,600</b>

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 (TDD: 711).

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 by emailing [contact@hcrcompliance.com](mailto:contact@hcrcompliance.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 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 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 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (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 أية 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, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 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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Ni da doodago t'áá háída biká'aná nilwo'ígíí díí Béeso Ách'ááh naa'níligi háá'ída yí na' ídít kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíí bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'í' ha desdizih nínizingo, koji' béesh bee hólne' 1-844-516-6328. (Navajo)

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