



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.BlueChoiceSC.com or by calling 1-800-868-2528.

Important Questions	Answers	Why this Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>\$5,600 person / \$11,200 Family for in-network; \$11,200 person / \$22,400 Family for out-of-network. Doesn't apply to preventive care and prescription medications. Copays do not accumulate towards deductible.</p>	<p>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>Yes, \$150 for brand name prescription drug expenses. There are no other specific deductibles.</p>	<p>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</p>
<p>Is there an <u>out-of-pocket limit</u> on my expenses?</p>	<p>Yes. \$6,600 person / \$13,200 Family for in-network; \$13,200 person / \$26,400 Family for out-of-network</p>	<p>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Premiums, balance-billed charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Does this plan use a <u>network of providers</u>?</p>	<p>Yes. For a list of participating providers see www.BlueChoiceSC.com or call 1-800-868-2528.</p>	<p>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</p>
<p>Do I need a referral to see a <u>specialist</u>?</p>	<p>No. You don't need a referral to see a specialist.</p>	<p>You can see the specialist you choose without permission from this plan.</p>
<p>Are there services this plan doesn't cover?</p>	<p>Yes</p>	<p>Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.</p>

Questions: Call 1-800-868-2528 or visit us at www.BlueChoiceSC.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at <http://dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call to request a copy. BlueChoice HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association.



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$45 co-pay / visit	50% co-insurance	—————none—————
	Specialist visit	\$60 co-pay / visit, then 40% co-insurance	50% co-insurance	—————none—————
	Other practitioner office visit	\$60 co-pay / visit, then 40% co-insurance	50% co-insurance	—————none—————
	Preventive care/screening/immunization	\$0	Not Covered	—————none—————
If you have a test	Diagnostic test (x-ray, blood work)	40% co-insurance	50% co-insurance	—————none—————
	Imaging (CT/PET scans, MRIs)	40% co-insurance	50% co-insurance	—————none—————
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com .	Tier 1	\$8 co-pay retail	Not Covered	Covers up to a 31-day supply retail prescription. You will have to pay more if you select a brand-name drug instead of a generic drug. Certain prescriptions may require prior authorization or have dosage limits.
	Tier 2	\$25 co-pay retail		
	Tier 3	\$45 co-pay retail	Not Covered	
	Tier 4	\$70 co-pay retail	Not Covered	
	Tier 5 Tier 6	\$125 co-pay retail \$175 co-pay retail	Not Covered	

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% co-insurance	50% co-insurance	Ambulatory Surgery Center covered at \$60 per visit, then 40% co-insurance
	Physician/surgeon fees	40% co-insurance	50% co-insurance	—————none—————
If you need immediate medical attention	Emergency room services	\$300 co-pay / visit then 40%	\$300 co-pay / visit then 40%	—————none—————
	Emergency medical transportation	40% co-insurance	50% co-insurance	—————none—————
	Urgent care	\$60 co-pay / visit	50% co-insurance	Must be a participating Urgent Care provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% co-insurance	50% co-insurance	Prior authorization required.
	Physician/surgeon fee	40% co-insurance	50% co-insurance	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	40% co-insurance	50% co-insurance	Prior authorization required except for urgent care.
	Mental/Behavioral health inpatient services	40% co-insurance	50% co-insurance	
	Substance use disorder outpatient services	40% co-insurance	50% co-insurance	
	Substance use disorder inpatient services	40% co-insurance	50% co-insurance	
If you are pregnant	Prenatal and postnatal care	\$60 co-pay first visit, then 40%	50% co-insurance	No additional co-pay for ongoing routine care
	Delivery and all inpatient services	40% co-insurance	50% co-insurance	Prior authorization required Home births are not covered
If you need help recovering or have other special health needs	Home health care	40% co-insurance	50% co-insurance	—————none—————
	Rehabilitation services	40% co-insurance	Not Covered	Prior authorization required. 20 visits each per Benefit Period for physical therapy, speech therapy and occupational therapy.
	Habilitation services	Not Covered	Not Covered	—————none—————
	Skilled nursing care	40% co-insurance	50% co-insurance	Prior authorization required 120 days per Benefit Period
	Durable medical equipment	40% co-insurance	Not Covered	Prior Authorization required Initial device only
	Hospice service	40% co-insurance	50% co-insurance	Prior authorization required

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	—————none—————
	Glasses	Not Covered	Not Covered	—————none—————
	Dental check-up	Not Covered	Not Covered	—————none—————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services .)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Chiropractic Care • Cosmetic surgery 	<ul style="list-style-type: none"> • Dental care (Adult) • Hearing Aids • Infertility treatment • Long-term care 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-868-2528. You may also contact your state insurance department, the 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

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

To obtain assistance in your specific language, call the customer service number shown on the first page of this notice.
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-868-2528.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$1,300
- Patient pays \$6,240

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$5,620
Co-pays	\$0
Co-insurance	\$470
Limits or exclusions	\$150
Total	\$6,240

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$1,770
- Patient pays \$3,630

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$2,570
Co-pays	\$980
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$3,630

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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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@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).

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 [在此插入數字 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 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)

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 tinutulongan, 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 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)

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 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)
