BlueChoice HealthPlan South Carolina : **Blue Option℠ / Bronze 6500**

Coverage for: Individual/Family | **Plan Type:** EPO

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 1-855-816-7636 or visit us at www.BlueOptionSC.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?	$6,500 / Individual or $13,000 / 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.
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?	$9,300 / Individual or $18,600 / family for in-network	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.BlueOptionSC.com or call 1-855-816-7636 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.

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	$60 copay/office visit; deductible does not apply	Not Covered	Blue CareOnDemand℠ Powered by MDLive covered at $30 copay; deductible does not apply (Blue CareOnDemand is offered through MDLive, an independent company that provides telehealth hosting and software services on behalf of BlueChoice)
	Specialist visit	$110 copay/office visit; deductible does not apply	Not Covered	None
	Preventive care/screening/ immunization	No charge	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	Not Covered	Preauthorization is required.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.blueoptionsc.com/formulary	Tier 1	$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 to Tier 1 and Tier 2.
	Tier 2	$35 copay/retail prescription; $70 copay/mail order prescription		
	Tier 3	30% coinsurance/retail prescription; 30% coinsurance/mail order prescription	Not Covered	
	Tier 4	30% coinsurance/retail prescription; 30% coinsurance/mail	Not Covered	

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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)	
		order prescription		
	Tier 5 Tier 6	30% coinsurance/retail prescription; 30% coinsurance/mail order prescription 30% coinsurance/retail prescription; 30% coinsurance/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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not Covered	Preauthorization is required. Freestanding Ambulatory Surgical Center covered at $200 copay; deductible does not apply.
	Physician/surgeon fees	$300 copay, then deductible, then 30% coinsurance	Not Covered	Preauthorization is required
If you need immediate medical attention	Emergency room care	$300 copay, then deductible, then 30% coinsurance	Not Covered	In order for Emergency Room care to be covered, care must be for an Emergency Medical Condition
	Emergency medical transportation	30% coinsurance	Not Covered	Special rules apply to air ambulance
	Urgent care	$75 copay/visit; deductible does not apply	Not Covered	Must be at a participating Urgent Care provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay/stay, then deductible, then 30% coinsurance	Not Covered	Preauthorization is required
	Physician/surgeon fees	30% coinsurance	Not Covered	None

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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 mental health, behavioral health, or substance abuse services	Outpatient services	$60 copay/office visit and 30% coinsurance for other outpatient services	Not Covered	Some services require Preauthorization except for urgent care.
	Inpatient services	30% coinsurance	Not Covered	Some services require Preauthorization except for urgent care.
If you are pregnant	Office visits	$110 copay first visit; deductible does not apply	Not Covered	Preauthorization is required No additional co-pay for ongoing routine care Home births are not covered.
	Childbirth/delivery professional services	$300 copay/stay, then deductible, then 30% coinsurance	Not Covered	
	Childbirth/delivery facility services	$300 copay/stay, then deductible, then 30% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not Covered	Preauthorization is required ; 60 visits/year
	Rehabilitation services	30% coinsurance	Not Covered	Preauthorization is required; 30 visits/year. Includes physical therapy, speech therapy, and occupational therapy
	Habilitation services	30% coinsurance	Not Covered	30 visits/year
	Skilled nursing care	30% coinsurance	Not Covered	Preauthorization is required ; 60 days/year
	Durable medical equipment	30% coinsurance	Not Covered	Preauthorization is required; up to purchase price
	Hospice services	30% coinsurance	Not Covered	Preauthorization is required; 6 months per episode
If your child needs dental or eye care	Children's eye exam	$15	Not covered	One comprehensive exam every Benefit Period. Refer to your plan document for a full list of limits/exceptions.
	Children's glasses	$25	Not covered	$150 will be allowed toward the purchase of frames, lenses, lens options or contacts Refer to your plan document for a full list of limits/exceptions. Consult your PEN Provider for more information on discounts for which you may be eligible

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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)	
	Children's dental check-up	Balance over $50	Not covered	No dental network out-of-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
- Chiropractic Care
- Cosmetic Surgery
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Private Duty Nursing
- Routine Foot Care

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

- Dental Care (Adult)
- Habilitation
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight Loss Programs (when participating in approved program)

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 1-855-816-7636 or visit www.BlueOptionSC.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**.
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 Minimum Value Standards? **Not Applicable**.

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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

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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	$6,500
Specialist copayment	$110
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	$6,500
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,960**

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

The plan's overall deductible	$6,500
Specialist copayment	$110
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$4,000
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,820**

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

The plan's overall deductible	$6,500
Specialist copayment	$110
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$2,500
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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 or by calling 1-800-868-2528..
*Note: This plan may have other deductibles for specific services included in these examples. See "Are there other deductibles for specific services?" row above.

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