
 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](http://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:
<b>What is the overall <a href="#">deductible</a>?</b>	\$4,500 / Individual or \$9,000 / family for <a href="#">in-network</a>	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$8,900 / Individual or \$17,800 / family for <a href="#">in-network</a>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.BlueOptionSC.com">www.BlueOptionSC.com</a> or call 1-855-816-7636 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No	You can see the <a href="#">specialist</a> 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$35 <a href="#">copay</a> /office visit; <a href="#">deductible</a> does not apply	Not Covered	Blue CareOnDemand <sup>SM</sup> Powered by MDLive covered at \$18 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply (Blue CareOnDemand is offered through MDLive, an independent company that provides telehealth hosting and software services on behalf of BlueChoice)
	<a href="#">Specialist</a> visit	\$80 <a href="#">copay</a> /office visit; <a href="#">deductible</a> does not apply	Not Covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	50% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required.
	Imaging (CT/PET scans, MRIs)	50% <a href="#">coinsurance</a>	Not Covered	
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.blueoptionsc.com/formulary">https://www.blueoptionsc.com/formulary</a>	Tier 1	\$25 <a href="#">copay</a> /retail prescription; \$50 <a href="#">copay</a> /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).  <a href="#">Deductible</a> does not apply
	Tier 2	\$50 <a href="#">copay</a> /retail prescription; \$100 <a href="#">copay</a> /mail order prescription		
	Tier 3	\$90 <a href="#">copay</a> /retail prescription; \$180 <a href="#">copay</a> /mail order prescription	Not Covered	
	Tier 4	\$300 <a href="#">copay</a> /retail prescription; \$600 <a href="#">copay</a> /mail order	Not Covered	

\*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.BlueOptionSC.com](http://www.BlueOptionSC.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)	
		prescription		
	Tier 5	\$300 <a href="#">copay</a> /retail prescription; \$600 <a href="#">copay</a> /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.  <a href="#">Deductible</a> does not apply
Tier 6	\$300 <a href="#">copay</a> /retail prescription; \$600 <a href="#">copay</a> /mail order prescription			
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	50% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required. Freestanding Ambulatory Surgical Center covered at \$200 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply.
	Physician/surgeon fees	\$100 <a href="#">copay</a> , then <a href="#">deductible</a> , then 50% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$300 <a href="#">copay</a> , then <a href="#">deductible</a> , then 50% <a href="#">coinsurance</a>	Not Covered	In order for Emergency Room care to be covered, care must be for an Emergency Medical Condition
	<a href="#">Emergency medical transportation</a>	50% <a href="#">coinsurance</a>	Not Covered	Special rules apply to air ambulance
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	Not Covered	Must be at a participating Urgent Care provider.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	50% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required
	Physician/surgeon fees	50% <a href="#">coinsurance</a>	Not Covered	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$35 <a href="#">copay</a> /office visit and 50% <a href="#">coinsurance</a> for other outpatient services	Not Covered	Some services require <a href="#">Preauthorization</a> except for urgent care.
	Inpatient services	50% <a href="#">coinsurance</a>	Not Covered	Some services require <a href="#">Preauthorization</a> except for urgent care.
<b>If you are pregnant</b>	Office visits	0% <a href="#">coinsurance</a> ;	Not Covered	<a href="#">Preauthorization</a> is required

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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)	
		<a href="#">deductible</a> does not apply		Home births are not covered.
	Childbirth/delivery professional services	50% <a href="#">coinsurance</a>	Not Covered	
	Childbirth/delivery facility services	50% <a href="#">coinsurance</a>	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	50% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required; 60 visits/year
	<a href="#">Rehabilitation services</a>	50% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required; 30 visits/year. Includes physical therapy, speech therapy, and occupational therapy
	<a href="#">Habilitation services</a>	50% <a href="#">coinsurance</a>	Not Covered	30 visits/year
	<a href="#">Skilled nursing care</a>	50% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required; 60 days/year
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required; up to purchase price
	<a href="#">Hospice services</a>	50% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required; 6 months per episode
<b>If your child needs dental or eye care</b>	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; 100% coverage for <a href="#">Provider</a> designated frames	Not covered	Refer to your plan document for a full list of limits/exceptions. Consult your EyeMed Provider for more information on discounts for which you may be eligible
	Children's dental check-up	Balance over \$50	Not covered	No dental network out-of-network

\*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.BlueOptionSC.com](http://www.BlueOptionSC.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](#).)

- Acupuncture
- Bariatric Surgery
- 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.)

- Chiropractic Care
- 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](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 [www.HealthCare.gov](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: BlueChoice HealthPlan at 1-855-816-7636 or visit [www.BlueOptionSC.com](http://www.BlueOptionSC.com), the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://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](mailto: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, kwijigo 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](#) \$4,500
- [Specialist copayment](#) \$80
- [Hospital \(facility\) coinsurance](#) 50%
- [Other coinsurance](#) 50%

**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	
Deductibles	\$4,500
Copayments	\$10
Coinsurance	\$2,700
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$7,270</b>

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

- The [plan's overall deductible](#) \$4,500
- [Specialist copayment](#) \$80
- [Hospital \(facility\) coinsurance](#) 50%
- [Other coinsurance](#) 50%

**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	
Deductibles*	\$900
Copayments	\$1,800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,720</b>

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

- The [plan's overall deductible](#) \$4,500
- [Specialist copayment](#) \$80
- [Hospital \(facility\) coinsurance](#) 50%
- [Other coinsurance](#) 50%

**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	
Deductibles*	\$2,500
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,700</b>

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](http://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.