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 1-800-760-9290**. 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 **www.dol.gov/ebsa/healthreform** or **www.cciio.cms.gov** or call **1-800-760-9290** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	RSFH Owned/Affiliated **$500** person/**$1,000** family. BlueCross Network **$500** person/**$1,000** family.	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 the deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. RSFH Owned/Affiliated and BlueCross Network preventive 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?	RSFH Owned/Affiliated **$3,000** person/ **$6,000** family. BlueCross Network **$3,000** person/ **$6,000** family.Prescription drug **$1,200** person/ **$2,400** family**.**	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 and health care this plan does not 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.southcarolinablues.com** or call **1-800-810-BLUE (2583)** for a list of network providers.	This plan uses a provider network. You pay the least if you use a provider in Tier 1 - RSFH Owned. You pay more if you use a provider in Tier 2 – RSFH Affiliated and Tier-3 – BlueCross 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 you 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
		RSFH Owned Provider (You will pay the least)	RSFH Affiliated Provider (You will pay more)	BlueCross Network Provider (You will pay more)	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	$20 Copay/visit	$20 Copay/visit	$30 Copay/visit	Not Covered	Allergy injections are covered at No Charge; dialysis is covered at 20% Coinsurance for RSFH Owned/Affiliated and 25% Coinsurance for BlueCross Network.
	Specialist visit	$60 Copay/visit	$60 Copay/visit	$70 Copay/visit	Not Covered	
	Preventive care/screening/ immunization	No Charge	No Charge	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)	$20 Copay for labwork, $50 Copay for x-rays	$40 Copay for labwork, $75 Copay for x-rays	$40 Copay for labwork, $75 Copay for x-rays	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$100 Copay/test	$150 Copay/test	$150 Copay/test	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		RSFH Owned Provider (You will pay the least)	RSFH Affiliated Provider (You will pay more)	BlueCross Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** contact your employer	Generic drugs (Retail)	$10 Copay/ prescription	$10 Copay/ prescription	$10 Copay/ prescription	Not Covered	Contact Express Scripts customer service at 1-844-730-1971 for benefit details. Prescription drug out-of-pocket limit is $1,200 person/ $2,400 family.
	Generic drugs (Mail Order)	$20 Copay/ prescription	$20 Copay/ prescription	$20 Copay/ prescription	Not Covered	
	Preferred brand drugs (Retail)	$35 Copay/ prescription	$35 Copay/ prescription	$35 Copay/ prescription	Not Covered	
	Preferred brand drugs (Mail Order)	$87.50 Copay/ prescription	$87.50 Copay/ prescription	$87.50 Copay/ prescription	Not Covered	
	Non-preferred brand drugs (Retail)	40% Coinsurance with $50 Copay minimum, $150 Copay maximum	40% Coinsurance with $50 Copay minimum, $150 Copay maximum	40% Coinsurance with $50 Copay minimum, $150 Copay maximum	Not Covered	
	Non-preferred brand drugs (Mail Order)	40% Coinsurance with $125 Copay minimum, $375 Copay maximum	40% Coinsurance with $125 Copay minimum, $375 Copay maximum	40% Coinsurance with $125 Copay minimum, $375 Copay maximum	Not Covered	
	Specialty drugs	$50 Copay/ prescription	$50 Copay/ prescription	$50 Copay/ prescription	Not Covered	Select Limited Distribution specialty drugs have a copay of $150 for a 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	25% Coinsurance	25% Coinsurance	Not Covered	Nerve blocks and epidural steroid injections performed at RSFH Owned and Affiliated are subject to a $60 copay, BlueCross Network is subject to a $70 copay. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
	Physician/surgeon fees	20% Coinsurance	20% Coinsurance	25% Coinsurance	Not Covered	None
If you need immediate medical	Emergency room care	$250 Copay/visit	$250 Copay/visit	$250 Copay/visit	$250 Copay/visit	Copay will be waived if admitted.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		RSFH Owned Provider (You will pay the least)	RSFH Affiliated Provider (You will pay more)	BlueCross Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
attention	Emergency medical transportation	20% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance	None
	Urgent care	$20 Copay/visit	$60 Copay/visit	$60 Copay/visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	20% Coinsurance	25% Coinsurance	Not Covered	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
	Physician/surgeon fees	20% Coinsurance	20% Coinsurance	25% Coinsurance	Not Covered	Physician/surgeon fees for Skilled Nursing Care are covered for BlueCross Network at 20% Coinsurance.
If you need mental health, behavioral health, or substance abuse services	Mental/behavioral health outpatient services	20% Coinsurance	20% Coinsurance	20% Coinsurance	Not Covered	$20 Copay/Primary Care Physician office visit, $60 Copay/Specialist office visit.
	Substance use disorder outpatient services	20% Coinsurance	20% Coinsurance	20% Coinsurance	Not Covered	
	Mental/behavioral health inpatient services	20% Coinsurance	20% Coinsurance	20% Coinsurance	Not Covered	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board. Pre-authorization is not required for 4th St. Jude Behavior Medicine.
	Substance use disorder inpatient services	20% Coinsurance	20% Coinsurance	20% Coinsurance	Not Covered	
If you are pregnant	Office visits	$20 Copay/visit	$20 Copay/visit	$30 Copay/visit	Not Covered	Pre-authorization for facility services is required. Penalty for not obtaining pre-authorization is denial of room and board. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% Coinsurance	20% Coinsurance	25% Coinsurance	Not Covered	
	Childbirth/delivery facility services	20% Coinsurance	20% Coinsurance	25% Coinsurance	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		RSFH Owned Provider (You will pay the least)	RSFH Affiliated Provider (You will pay more)	BlueCross Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	20% Coinsurance	25% Coinsurance	Not Covered	Limited to 100 visits/benefit year. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
	Rehabilitation services	$60 Copay/ condition	$60 Copay/ condition	$70 Copay/ condition	Not Covered	Occupational, Physical and Speech Therapy are limited to 40 combined visits/benefit year. BlueCross Network pediatric services are covered, $60 Copay/condition.
	Habilitation services	$60 Copay/ condition	$60 Copay/ condition	$70 Copay/ condition	Not Covered	
	Skilled nursing care	20% Coinsurance	20% Coinsurance	20% Coinsurance	Not Covered	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
	Durable medical equipment	20% Coinsurance	20% Coinsurance	20% Coinsurance	Not Covered	Purchase or rentals of $500 or more requires pre-authorization. Penalty for not obtaining pre-authorization is denial of all charges.
	Hospice services	20% Coinsurance	20% Coinsurance	20% Coinsurance	Not Covered	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board for Inpatient RSFH Owned/Affiliated and denial of all charges for BlueCross Network Inpatient and Outpatient facilities.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	Not Covered	Not Covered	

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
- Cosmetic surgery
- Dental Care (Adult)
- Dental Care (Child)
- Hearing aids
- Infertility treatment
- Long term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Child)
- Routine foot care

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

- Bariatric surgery, $30,000 lifetime max including reconstructive surgery
- Chiropractic care, $1,000 annual max
- Weight loss programs

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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**. 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: 1-800-760-9290 or visit us at **www.SouthCarolinaBlues.com**, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **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.

Language Access Services:

Spanish: Para obtener asistencia en español, llame al número de atención al cliente que aparece en la primera página de esta notificación.

Taglog: Upang makakuha ng tulong sa Tagalog, tawagan ang numero ng *customer service* na makikita sa unang pahina ng paunawang ito.

Chinese: T'áá Dinéjí shił hane'go shíká i'doolwoł ninízingo éí Nidaalnishígíí Áká Anidaalwo'igíí, customer service, bich'į' hodíilnih. Bik'ehgo bich'į' hane'igíí éí díí naaltsoos neiyí'nilígíí akáa'gi siłtsoozígíí bikáá' íishją́ąh.

Navajo:

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

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 RSFH Owned network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist Copayment	$60
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	$500
Copayments	$810
Coinsurance	$1,690
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	$500
Specialist Copayment	$60
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1,370
Coinsurance	$250
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,180**

Mia's Simple Fracture
(RSFH Owned network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist Copayment	$60
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$530
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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: 1-800-760-9290

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