

 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 <u>deductible</u>?	RSFH Owned/Affiliated and BlueCross \$500 person/ \$1,000 family.	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 the <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. RSFH Owned/Affiliated <u>preventive care</u> or chiropractic services are covered before you meet your <u>deductible</u> .	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	RSFH Owned/Affiliated and BlueCross Network \$3,000 person/ \$6,000 family. Prescription drug \$1,200 person/ \$2,400 family.	The <u>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>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> and health care this <u>plan</u> does not cover. Additionally, certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.southcarolinablues.com or call 1-800-810-BLUE (2583) for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You pay the least if you use a <u>provider</u> in Tier 1 - RSFH Owned. You pay more if you use a <u>provider</u> in Tier 2 – RSFH Affiliated and Tier-3 – BlueCross Network. 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 you <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.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		<u>RSFH Owned Provider</u> (You will pay the least)	<u>RSFH Affiliated Provider</u> (You will pay more)	<u>BlueCross Network Provider</u> (You will pay more)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>Copay</u> /visit	\$20 <u>Copay</u> /visit	Not Covered	Not Covered	Allergy injections are covered at No Charge; dialysis is covered at 20% <u>Coinsurance</u> for RSFH Owned/Affiliated.
	<u>Specialist</u> visit	\$60 <u>Copay</u> /visit	\$60 <u>Copay</u> /visit	Not Covered	Not Covered	
	<u>Preventive care/screening/immunization</u>	No Charge	No Charge	Not Covered	Not Covered	See www.healthcare.gov for preventive care guidelines. There may be additional benefits available. See your Employer for details. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$20 <u>Copay</u> for lab work, \$50 <u>Copay</u> for x-rays	50% <u>Coinsurance</u>	Not Covered	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$100 <u>Copay</u> /test	50% <u>Coinsurance</u>	Not Covered	Not Covered	None

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

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

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		<u>RSFH Owned Provider</u> (You will pay the least)	<u>RSFH Affiliated Provider</u> (You will pay more)	<u>BlueCross Network Provider</u> (You will pay more)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	Not Covered	Not Covered	Limited to 100 visits/benefit year. <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of all charges.
	<u>Rehabilitation services</u>	\$60 <u>Copay</u> / condition	\$60 <u>Copay</u> / condition	Not Covered	Not Covered	Occupational, Physical and Speech Therapy are limited to 40 combined visits/benefit year. BlueCross Network pediatric services are covered, \$60 <u>Copay</u> /condition.
	<u>Habilitation services</u>	\$60 <u>Copay</u> / condition	\$60 <u>Copay</u> / condition	Not Covered	Not Covered	
	<u>Skilled nursing care</u>	20% Coinsurance	20% Coinsurance	20% Coinsurance	Not Covered	<u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of room and board.
	<u>Durable medical equipment</u>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	Not Covered	Purchase or rentals of \$500 or more requires <u>pre-authorization</u> . Penalty for not obtaining <u>pre-authorization</u> is denial of all charges. Wrist splints are Not Covered for BlueCross Network. Breast pumps are covered at No Charge, limited to \$150.
	<u>Hospice services</u>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	Not Covered	Limited to \$3,000/episode Out-of-Network. <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> 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.)

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

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

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| • Bariatric surgery, \$30,000 lifetime max including reconstructive surgery | • Chiropractic care, \$1,000 annual max | • Weight loss programs |
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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**

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 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: 如需中文服务, 请致电列于本通知首页的客户服务号码。

Navajo: T'áá Dinéji shíł hanc'go shiká i'doolwoł ninizingo éi Nidaalnishigíi Aká Anidaalwo'igíi, customer service, bich'í' hodiilnih. Bik'ehgo bich'í' hanc'igíi éi díi naaltsoos neiyi'niligíi akáa'gi siltsoozigíi bikáá' íishjááh.

—————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
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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
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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
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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