South Carolina **Roper St. Francis Healthcare: Flex Plan**

Coverage Period: 01/01/2025 – 12/31/2025
Coverage for: Individual or Family | Plan Type: PPO

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 **https://www.healthcare.gov/sbc-glossary** 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?	RSFHA Owned **$1,300** person/ **$2,600** family. RSFHA Affiliate **$1,300** person/ **$2,600** family. BlueCross Network **$2,000** person/ **$4,000** family.	Generally, you must pay all 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.** RSFHA Owned and RSFHA Affiliate preventive care and chiropractic 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 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?	RSFHA Owned **$3,000** person**/ $6,000** family. RSFHA Affiliate **$4,750** person**/ $9,500** family. BlueCross Network **$3,500** person**/ $7,000** 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 charges, and health care this plan doesn't 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 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.	You pay the least if you use an RSFHA Owned provider. You pay more if you use an RSFHA Affiliate provider or a BlueCross Network provider. 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
		RSFHA Owned Provider (You will pay the least)	RSFHA Affiliate 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	$25 Copay/visit	$25 Copay/visit	$35 Copay/visit	Not Covered	Allergy injections are covered at No Charge; dialysis is covered at 15% Coinsurance for RSFHA Owned and 20% Coinsurance for RSFHA Affiliate/BlueCross Network.
	Specialist visit	$60 Copay/visit	$60 Copay/visit	$70 Copay/visit	Not Covered	Allergy injections are covered at No Charge; dialysis is covered at 15% Coinsurance for RSFHA Owned and 20% Coinsurance for RSFHA Affiliate/BlueCross Network.
	Preventive care/screening/ Immunization	No Charge	No Charge, except 50% Coinsurance for mammograms/ colonoscopies	50% Coinsurance, except No Charge for Annual Physicals and Well-Woman Visits	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 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)	$25 Copay for lab work, $50 Copay for x-rays	50% Coinsurance	50% Coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$100 Copay/test	50% Coinsurance	50% Coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		RSFHA Owned Provider (You will pay the least)	RSFHA Affiliate 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	High Cost generic drugs (Retail) $20 Copay/prescription. Contact MedImpact customer service at 1 888 783 1780 for benefit details. Contact Harness Pharmacy customer service at 1 866 775 5767 for Mail and Specialty pharmacy services. After 1 grace fill for maintenance medications members are required to convert to 90 day supply at Harness mail. 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	High cost generic drugs (Mail Order) $40 Copay/prescription. Contact MedImpact customer service at 1 888 783 1780 for benefit details.
	Preferred brand drugs (Retail)	$35 Copay/ prescription	$35 Copay/ prescription	$35 Copay/ prescription	Not Covered	Contact MedImpact customer service at 1 888 783 1780 for benefit details.
	Preferred brand drugs (Mail Order)	$87.50 Copay/ prescription	$87.50 Copay/ prescription	$87.50 Copay/ prescription	Not Covered	Contact MedImpact customer service at 1 888 783 1780 for benefit details.

	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	Contact MedImpact customer service at 1 888 783 1780 for benefit details.
	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	Contact MedImpact customer service at 1 888 783 1780 for benefit details.
	Specialty Drugs	$50 Copay/ prescription for Preferred and $100 Copay/prescription for Non-Preferred	$50 Copay/ prescription for Preferred and $100 Copay/prescription for Non-Preferred	$50 Copay/ prescription for Preferred and $100 Copay/prescription for Non-Preferred	Not Covered	Contact MedImpact customer service at 1 888 783 1780 for benefit details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% Coinsurance	50% Coinsurance	50% Coinsurance	Not Covered	Nerve blocks and epidural steroid injections performed at RSFH Owned and Affiliate are subject to a $60 copay, and $70 copay for BlueCross network.. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
	Physician/surgeon fees	15% Coinsurance	20% Coinsurance	50% Coinsurance	Not Covered	None

	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		RSFHA Owned Provider (You will pay the least)	RSFHA Affiliate Provider (You will pay more)	BlueCross Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	

If you need immediate medical attention	Emergency room care	$250 Copay/visit, then 10% Coinsurance; deductible does not apply	$250 Copay/visit, then 10% Coinsurance; deductible does not apply	$250 Copay/visit, then 10% Coinsurance; deductible does not apply	$250 Copay/visit, then 10% Coinsurance; deductible does not apply	Copay will be waived if admitted.
	Emergency medical transportation	15% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance	None
	Urgent care	$40 Copay/visit	$40 Copay/visit	$70 Copay/visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% Coinsurance	20% Coinsurance	50% Coinsurance	Not Covered	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
	Physician/surgeon fees	15% Coinsurance	20% Coinsurance	50% Coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Mental/behavioral health outpatient services	15% Coinsurance	20% Coinsurance	20% Coinsurance	Not Covered	$25 Copay/Primary Care Physician office visit, $60 Copay/Specialist office visit
	Substance use disorder outpatient services	15% Coinsurance	20% Coinsurance	20% Coinsurance	Not Covered	
	Mental/behavioral health inpatient services	15% 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	15% Coinsurance	20% Coinsurance	20% Coinsurance	Not Covered	
If you are pregnant	Office visits	$25 Copay/visit	$25 Copay/visit	$35 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 coinsurance or deductible may apply. Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	15% Coinsurance	20% Coinsurance	50% Coinsurance	Not Covered	
	Childbirth/delivery facility services	15% Coinsurance	20% Coinsurance	50% Coinsurance	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		RSFHA Owned Provider (You will pay the least)	RSFHA Affiliate 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	15% Coinsurance	20% Coinsurance	50% 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	Occupational, Physical and Speech Therapy are limited to 40 combined visits/benefit year. BlueCross Network pediatric services are covered, $60 Copay/condition.
	Skilled nursing care	15% 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	15% 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. Wrist splints are Not Covered for BlueCross Network. Breast pumps are covered at No Charge, limited to $150.
	Hospice services	15% Coinsurance	20% Coinsurance	20% Coinsurance	Not Covered	Limited to $3,000/episode Out-of-Network. Pre-authorization is required. Penalty for not obtaining pre- authorization is denial of room and board for Inpatient RSFHA Owned/Affiliate 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	See your Employer for benefit details.
	Children's glasses	Not Covered	Not Covered	Not Covered	Not Covered	See your Employer for benefit details.
	Children's dental check-up	Not Covered	Not Covered	Not Covered	Not Covered	See your Employer for benefit details.

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 • 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	• Infertility Treatment, See your Benefit Booklet for additional benefit details. • Non-emergency care when traveling outside the United States • 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 Health and Human Services Center for Consumer Information and Insurance Oversight, 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 on how 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: 1-800-922-1185 or visit us at www.SouthCarolinaBlues.com

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 Dinéjí shił hane'go shiká i'doolwoł ninizingo éí Nidaalnishígíí Áká Anídaalwo'ígíí, customer service, bich'į' hodíílnih. Bik'ehgo bich'į' hane'ígíí éí díí naaltsoos neiyí'nilígíí akáa'gi siłtsoozígíí bikáá' íishjááh.

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 RSFHA 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	$1690
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 RSFHA 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	**$5,600**

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
(RSFHA 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	**$2,800**

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:**1-800-922-1185.**

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

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 (TDD: 711).

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 by emailing 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 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 đở 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 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, 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 تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية 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, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 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 بارهٔ این برنامهٔ 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 شمارهٔ 1-844-398-6233 تماس حاصل نمایید.
(Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ą́h naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshį́į́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į́' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)