City of Beaufort : HDHP Plan

South Carolina

Coverage Period: 07/01/2015 - 06/30/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | **Plan Type**: PPO with HSA

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.SouthCarolinaBlues.com** or by calling **1-800-760-9290**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network **$1,300** person/**$2,600** family. Out-of-Network **$1,300** person/**$2,600** family. Does not apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-Network **$4,300** person/**$8,600** family. Out-of-Network **$7,250** person/**$14,500** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.SouthCarolinaBlues.com** or call **1-800-810-BLUE (2583)** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the Excluded Services and Other Covered Services section. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-760-9290** or visit us at www.SouthCarolinaBlues.com**.** If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call **1-800-760-9290** to request a copy.

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BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible.**
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% Coinsurance	50% Coinsurance	——none——
	Specialist visit	30% Coinsurance	50% Coinsurance	——none——
	Other practitioner office visit	30% Coinsurance	50% Coinsurance	Chiropractic services are limited to $1,500 per benefit year.
	Preventive care/screening/immunization	No Charge	Not Covered	See www.healthcare.gov for preventive care guidelines. There may be additional benefits available. See your Employer for details.
If you have a test	Diagnostic test (x-ray, blood work)	30% Coinsurance	50% Coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	50% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
If you need drugs to treat your illness or condition	Generic drugs (Retail)	30% Coinsurance per prescription	50% Coinsurance per prescription	90 day supply.
	Generic drugs (Mail Order)	30% Coinsurance per prescription	Not Covered	90 day supply.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
More information about **prescription drug coverage** is available at www.SouthCarolinaBlues.com	Preferred brand drugs (Retail)	30% Coinsurance per prescription	50% Coinsurance per prescription	90 day supply.
	Preferred brand drugs (Mail Order)	30% Coinsurance per prescription	Not Covered	90 day supply.
	Non-preferred brand drugs (Retail)	30% Coinsurance per prescription	50% Coinsurance per prescription	90 day supply.
	Non-preferred brand drugs (Mail Order)	30% Coinsurance per prescription	Not Covered	90 day supply.
	Specialty drugs	30% Coinsurance per prescription	Not Covered	Up to a 90 day supply. Available at Accredo Specialty Pharmacy only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	50% Coinsurance	Pre-authorization is required for some outpatient surgeries. Penalty for not obtaining pre-authorization is 50% of the allowable charge.
	Physician/surgeon fees	30% Coinsurance	50% Coinsurance	——none——
If you need immediate medical attention	Emergency room services	30% Coinsurance	30% Coinsurance	——none——
	Emergency medical transportation	30% Coinsurance	30% Coinsurance	——none——
	Urgent care	30% Coinsurance	50% Coinsurance	——none——

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance	50% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
	Physician/surgeon fee	30% Coinsurance	50% Coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% Coinsurance	50% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is 50% of the allowable charge.
	Mental/Behavioral health inpatient services	30% Coinsurance	50% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
	Substance use disorder outpatient services	30% Coinsurance	50% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is 50% of the allowable charge.
	Substance use disorder inpatient services	30% Coinsurance	50% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
If you are pregnant	Prenatal and postnatal care	30% Coinsurance	50% Coinsurance	——————none——————
	Delivery and all inpatient services	30% Coinsurance	50% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
If you need help recovering or have other special health needs	Home health care	30% Coinsurance	50% Coinsurance	Limited to 60 visits per benefit year. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
	Rehabilitation services	30% Coinsurance	50% Coinsurance	Occupational Therapy & Physical Therapy limited to a combined 30 visits per benefit year. Speech Therapy limited to 20 visits per benefit year. Limitations are combined with Habilitation services.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
	Habilitation services	30% Coinsurance	50% Coinsurance	Occupational Therapy & Physical Therapy limited to a combined 30 visits per benefit year. Speech Therapy limited to 20 visits per benefit year. Limitations are combined with Rehabilitation services.
	Skilled nursing care	30% Coinsurance	50% Coinsurance	Limited to 60 days per benefit year. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of room and board.
	Durable medical equipment	30% Coinsurance	Not Covered	Purchase or rentals of $500 or more require pre-authorization. Penalty for not obtaining pre-authorization is denial of all charges.
	Hospice service	30% Coinsurance	50% Coinsurance	Limited to 6 months per episode. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	See your Employer for benefit details.
	Glasses	Not Covered	Not Covered	See your Employer for benefit details.
	Dental check-up	Not Covered	Not Covered	See your Employer for benefit details.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- 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

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Weight Loss Programs

Other Covered Services. (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic Care
- Most coverage provided outside the U.S. See www.SouthCarolinaBlues.com
- Non-emergency care when traveling outside the United States.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-760-9290. You may also contact your state insurance department, the 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact any or all of the following:

- 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
- The South Carolina State Department of Insurance at 1-800-768-3467 or visit www.doi.sc.gov

Language Access Services:

To obtain assistance in your specific language, call the customer service number shown on the first page of this notice.
Spanish: Para obtener asistencia en español, llame al número de atención al cliente que aparece en la primera página de esta notificación.
Tagalog: 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 shíká i'doolwoł nínízingo éí Nidaalnishígíí Áká Anídaalwo'ígíí, customer service, bich'į' hodíilnih. Bik'ehgo bich'į' hane'ígíí éí díí naaltsoos neiyí'nilígíí akáa'gi siłtsoozígíí bikáá' ííshjąąh.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $4,300**
- **Patient pays $3,240**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,300
Copays	$0
Coinsurance	$1,790
Limits or exclusions	$150
Total	**$3,240**

These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-800-760-9290.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $2,830**
- **Patient pays $2,570**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,300
Copays	$0
Coinsurance	$1,190
Limits or exclusions	$80
Total	**$2,570**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call **1-800-760-9290** or visit us at www.SouthCarolinaBlues.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call **1-800-760-9290** to request a copy.