**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 1-833-983-7272 (TTY 711). 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.healthcare.gov/sbc-glossary/ or call 1-833-983-7272 (TTY 711) to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In Network: $5,500/Individual, $11,000/Family<br>Out of Network: Not Covered | 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 deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care/screening/immunization, children's eye exam and glasses, Primary Care, Specialist Care, Urgent Care, Mental/Behavioral Health Office Visits, Preferred generic drugs (Tier 1a), Non-preferred generic drugs (Tier 1b), Preferred brand drugs (Tier 2), Office visits for routine pregnancy, and Substance Abuse Office Visits do not apply toward the 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?** | In Network: $12,000/Individual, $24,000/Family<br>Out of Network: Not Covered | 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 limit 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, penalties for failure to obtain preauthorization for services 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.firstchoicenext.com or call 1-833-983-7272 (TTY 711) for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's 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 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 |
|---|---|---|---|---|
| | | In Network (You will pay the least) | Out of Network (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. | $40 copayment/visit, Deductible does not apply | Not Covered | None |
| | Specialist visit | $100 copayment/visit, Deductible does not apply | Not Covered | None |
| | Preventive care/screening/immunization | No Charge, Deductible does not apply | 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) | X-ray: 30% coinsurance<br>Blood work: 30% coinsurance | X-ray: Not Covered<br>Blood work: Not Covered | None. |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | Not Covered | Prior authorization may be required.<br>Covered no limit |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at https://welcome.benefitrx.com/firstchoicenext/prescription-drug-list | Preferred generic drugs (Tier 1a) | $5 copayment/prescription, Deductible does not apply | Not Covered | |
| | Non-preferred generic drugs (Tier 1b) | $25 copayment/prescription, Deductible does not apply | Not Covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In Network (You will pay the least) | Out of Network (You will pay the most) | |
| | Preferred brand drugs (Tier 2) | $60 copayment/prescription, Deductible does not apply | Not Covered | Prior authorization / step therapy may be required. Covers up to a 30-day supply (retail subscription); 31–90 day supply (mail order prescription). Cost share shown is per retail prescription. Mail order cost share is 2.5 times retail cost. |
| | Non-preferred brand and non-preferred (high cost) generic drugs (Tier 3) | 35% coinsurance | Not Covered | |
| | Specialty drugs (Tier 4a) | 40% coinsurance | Not Covered | |
| | Non-preferred specialty drugs (Tier 4b) | 50% coinsurance | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | Not Covered | Prior authorization may be required. Covered no limit. |
| | Physician/surgeon fees | 30% coinsurance | Not Covered | Prior authorization may be required. Covered no limit. |
| **If you need immediate medical attention** | Emergency room care | 30% coinsurance | 30% coinsurance | You pay the same level as in-network if it is an emergency as defined in your policy, otherwise not covered. |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In Network (You will pay the least) | Out of Network (You will pay the most) | |
| | Urgent care | $150 copayment/visit, Deductible does not apply | $150 copayment/visit, Deductible does not apply | Out-of-network Urgent Care services are covered when network providers are temporarily unavailable or inaccessible and if the services are for an urgent condition as defined in your plan policy, otherwise not covered. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance | Not Covered | Prior authorization may be required.<br>Covered no limit. |
| | Physician/surgeon fees | 30% coinsurance | Not Covered | Prior authorization may be required.<br>Covered no limit. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $40 copayment/office visit , Deductible does not apply<br><br>30% coinsurance for other outpatient services. | Not Covered | Covered no limit.<br>The cost sharing that displays next to office visit applies to outpatient office visits only. All other outpatient services may be subject to additional cost sharing. Please refer to the plan policy documents for detailed information. |
| | Inpatient services | 30% coinsurance | Not Covered | Prior authorization may be required.<br>Covered no limit. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In Network (You will pay the least) | Out of Network (You will pay the most) | |
| **If you are pregnant** | Office visits | No Charge, Deductible does not apply | Not Covered | Prior authorization may be required. Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 30% coinsurance | Not Covered | |
| | Childbirth/delivery facility services | 30% coinsurance | Not Covered | |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance | Not Covered | 60 visits per benefit period<br>Prior authorization may be required. |
| | Rehabilitation services | 30% coinsurance | Not Covered | 30 visits per benefit period for rehabilitative speech therapy; Combined limit of 30 visits per benefit period for rehabilitative physical and occupational therapy.<br>Prior authorization may be required. |
| | Habilitation services | 30% coinsurance | Not Covered | Prior authorization may be required.<br>Covered no limit. |
| | Skilled nursing care | 30% coinsurance | Not Covered | 60 days per benefit period<br>Prior authorization may be required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In Network (You will pay the least) | Out of Network (You will pay the most) | |
| | Durable medical equipment | 50% coinsurance | Not Covered | Prior authorization may be required.<br>Covered no limit. |
| | Hospice services | No Charge | Not Covered | 6 months per episode<br>Prior authorization may be required. |
| **If your child needs dental or eye care** | Children's eye exam | No Charge, Deductible does not apply | Not Covered | 1 exam per benefit period |
| | Children's glasses | No Charge, Deductible does not apply | Not Covered | 1 pair of children's eye glasses (with standard frames and lenses) or contact lenses per benefit period |
| | Children's dental check-up | Not Covered | Not Covered | None |

**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.)**

- Abortion (except in cases of rape, incest, or when life of mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

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

- Chiropractic care 30 visits per benefit period
- Routine foot care

**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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov, or South Carolina Consumer Services Division, P.O. Box 100105, Columbia, SC 29202-3105, Phone:1-803-737-6180 or 1-800-768-3467. Other options to continue coverage are 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: visit www.HealthCare.gov or call 1-800-318-2596.

**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?** **Not Applicable**

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 (Español): Para obtener asistencia en Español, llame al 1-833-983-7272.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-983-7272.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-983-7272.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-983-7272.

*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 | $5,500 |
| Specialist copayment | $100 |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**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 | $5,500 |
| Copayments | $10 |
| Coinsurance | $1,300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$6,870** |

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

| | |
|---|---|
| The plan's overall deductible | $5,500 |
| Specialist copayment | $100 |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**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 | $100 |
| Copayments | $1,400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,520** |

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

| | |
|---|---|
| The plan's overall deductible | $5,500 |
| Specialist copayment | $100 |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**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 | $2,600 |
| Copayments | $200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,800** |

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

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, phone: **1-800-368-1019 (TTY 1-800-537-7697)**. Complaint forms are available at **https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf**.

## We speak your language

We provide free language services and information to people whose primary language is not English. To talk to an interpreter, call the Member Services number on the back of your card.

Ofrecemos servicios lingüísticos e información sin cargo a las personas cuya lengua materna no es el inglés. Para hablar con un intérprete, llame al número de Servicios al Miembro que figura en el dorso de su tarjeta.

我们为母语非英语的人士提供免费的语言服务及信息。如需与翻译交谈，请拨打您的会员卡背面的会员服务部电话。

Chúng tôi cung cấp thông tin và các dịch vụ ngôn ngữ miễn phí cho những người có ngôn ngữ chính không phải là tiếng Anh. Để nói chuyện với thông dịch viên, hãy gọi đến số điện thoại của Dịch Vụ Hội Viên ở mặt sau thẻ của quý vị.

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Nous fournissons gratuitement des services linguistiques et des informations à ceux dont la langue principale n'est pas l'anglais. Pour communiquer avec un interprète, appelez l'équipe service aux adhérents au numéro indiqué au dos de votre carte.

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