THE INFO IN THIS PACKET IS ABOUT
<u>THE SECURE 2 PLAN (BUY UP OPTION)</u>

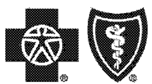
It is not mandatory that you choose insurance coverage. You may decline coverage if you wish.

Cost of this plan per bi-weekly paycheck is:

Employee Only	$122.25
Employee/Spouse	$543.24
Employee/Children	$409.34
Family	$770.04

If choosing this coverage, choose “BCBS – Buy Up Option Secure 2 Plan” on the Employee Deduction Authorization sheet, and on the Blue Cross Blue Shield Application form.

*Note – children can be covered through the age 25 if you choose Employee/Children coverage.



South Carolina **Chamber Blue Secure 2**

Coverage Period: 01/01/2020 - 12/31/2020
Coverage for: INDIVIDUAL-FAMILY | **Plan Type:** PPO

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

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 1-800-868-2500, Ext. 41010 to request a copy. 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 1-800-868-2500, Ext. 41010 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$2,500 single / $5,000 family for in-network providers. $5,000 single / $10,000 family for out-of-network providers. Doesn't apply to preventive care, prescription drugs or in-network doctor's office visits (if copay applies). Copayments do not count toward the deductible. The in-network and out-of-network amounts don't apply to each other.	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 services and office visits 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?	Yes. $500 Prescription Drug Deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the maximum out-of-pocket limit for this plan?	Yes; $7,000 single / $14,000 family for in-network providers. $14,000 single / $28,000 family for out-of-network providers. The in-network and out-of-network amounts don't apply to each other.	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 maximum out-of-pocket limit?	Copayments on certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the maximum out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. For a list of in-network providers, see https://www.SouthCarolinaBlues.com/links/tools/findadoctorsc or call 1-800-810-2583	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 I need a referral to see a specialist?	No.	You can see the **specialist** you choose without a referral.

All **copayments** 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
		Network Provider (You will pay the least)	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	$40 copay/visit	40% coinsurance	Copay doesn't include surgery, outpatient lab and X-ray services (except for standard plain film X-rays), second surgical opinion, dialysis, chemotherapy, radiation therapy, administration of specialty drugs, endoscopies and imaging.
	Specialist visit	$65 copay/visit	40% coinsurance	Copay doesn't include surgery, outpatient lab and X-ray services (except for standard plain film X-rays), second surgical opinion, dialysis, chemotherapy, radiation therapy, administration of specialty drugs, endoscopies and imaging.
	Preventive care/screening/immunization	No charge	Not covered	No charge for mammograms at a participating provider.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	NONE
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	No benefit if not preapproved.
If you need drugs to treat your illness or condition	Tier 1 Drugs	$8 copay/prescription (retail) $16 copay/prescription (mail-order) Prescription Drug Deductible does apply	$8 copay/prescription (retail) then 40% coinsurance	Prescription Drug deductible applies. Quantity limits may apply. Some drugs may require prior approval. No benefits if not approved. Drugs that are considered specialty drugs must be purchased from our Specialty Pharmacy, BriovaRx®.
	Tier 2 Drugs	$35 copay/prescription (retail) $80.50 copay/prescription (mail-order) Prescription Drug Deductible does apply	$35 copay/prescription (retail) then 40% coinsurance	Prescription Drug deductible applies. Quantity limits may apply. Some drugs may require prior approval. No benefits if not approved. Drugs that are considered specialty drugs must be purchased from our Specialty Pharmacy, BriovaRx®.

Common Medical Event	Services You May Need	What You Will Pay		Limitations , Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
More information about **prescription drug coverage** is available at **www.SouthCarolinaBlues.com/links/metallic/pharmacy/BusinessBlueEssentials**	Tier 3 Drugs	$70 copay/prescription (retail) $161 copay/prescription (mail-order) Prescription Drug Deductible does apply	$70 copay/prescription (retail) then 40% coinsurance	Prescription Drug deductible applies. Quantity limits may apply. Some drugs may require prior approval. No benefits if not approved. Drugs that are considered specialty drugs must be purchased from our Specialty Pharmacy, BriovaRx®.
	Tier 4 Drugs	20% up to $500 copay/prescription Prescription Drug Deductible does apply	Not covered	Prescription Drug deductible applies. Quantity limits may apply. Some drugs may require prior approval. No benefits if not approved. Drugs that are considered specialty drugs must be purchased from our Specialty Pharmacy, BriovaRx®.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	50% reduction of allowed amount if preapproval is required and not obtained. Cosmetic surgery is not covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	50% reduction of allowed amount if preapproval is required and not obtained. Cosmetic surgery is not covered.
If you need immediate medical attention	Emergency room care	$300 copay/visit, then 20% coinsurance after deductible	Facility charges only - $300 copay/visit, then 20% coinsurance after deductible. All other charges - 40% coinsurance.	NONE
	Emergency medical transportation	20% coinsurance	40% coinsurance	NONE
	Urgent care	$65 copay/visit	40% coinsurance	Copay doesn't include surgery, outpatient lab and X-ray services (except for standard plain film X-rays), second surgical opinion, dialysis, chemotherapy, radiation therapy, administration of specialty drugs, endoscopies and imaging.

Common Medical Event	Services You May Need	What You Will Pay		Limitations , Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/visit, then 20% coinsurance	40% coinsurance	Room and board denied if stay is not approved. No benefits for human organ/tissue transplant if not preapproved and at designated provider.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	No benefits for human organ/tissue transplant if not preapproved and at designated provider.
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	20% coinsurance	40% coinsurance	$40 copay/office visit in-network. 50% reduction of allowed amount if not preapproved.
	Inpatient services	20% coinsurance	40% coinsurance	Room and board denied if stay is not approved.
If you are pregnant	Office Visits	$40 copay/visit	40% coinsurance	Copay doesn't include surgery, outpatient lab and X-ray services (except for standard plain film X-rays), second surgical opinion, dialysis, chemotherapy, radiation therapy, administration of specialty drugs, endoscopies and imaging.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	For employee or spouse only. Covers screening for gestational diabetes and lactation support for dependent children.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	For employee or spouse only.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 60 visits/year. No benefits if not preapproved.
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical, occupational and speech therapy limited to 30 Rehabilitative visits/year combined. No inpatient benefits if not preapproved.
	Habilitation services	20% coinsurance	40% coinsurance	Physical, occupational and speech therapy limited to 30 Habilitative visits/year combined. No inpatient benefits if not preapproved.

Common Medical Event	Services You May Need	What You Will Pay		Limitations , Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 60 days/year. Room and board denied if stay is not approved.
	Durable medical equipment	20% coinsurance	Not covered	Excludes repair of, replacement of and duplicate. No benefits if not preapproved when cost is $500 or more.
	Hospice service	20% coinsurance	40% coinsurance	Limited to 6 months/episode. No benefits if not preapproved.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	NONE
	Children's glasses	Not covered	Not covered	NONE
	Children's dental check-up	Not covered	Not covered	NONE

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Eye exam (Child)
- Glasses (Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Private duty nursing
- Residential and custodial care
- Routine eye care (Adult)
- Routine foot care
- Routine maternity for dependent child
- 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
- Non-emergency care when traveling outside the U.S. See www.SouthCarolinaBlues.com/members/findaprovider.aspx

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 State Insurance Department, 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. 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 http://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: the plan at 1-800-868-2500, Ext. 41010 or visit www.SouthCarolinaBlues.com, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, your state office of health insurance customer assistance at: 1-800-768-3467 or visit www.doi.sc.gov.

Does this Coverage 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 Coverage Meet the Minimum Value Standard? 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.

*For more information about limitations and exceptions, see the plan or policy document at www.SouthCarolinaBlues.com.

——————————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 in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$65**
- **Hospital (facility) copayment** **$500**
- **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	$2,500
Copayments	$600
Coinsurance	$700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,860**

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

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$65**
- **Hospital (facility) copayment** **$500**
- **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	$600
Copayments	$1,400
Coinsurance	$30
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,090**

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

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$65**
- **Hospital (facility) copayment** **$500**
- **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	$900
Copayments	$1,100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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.

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 online at contact@hrcompliance.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，請撥電話 [在此插入數字 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 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (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, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 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)

Member Schedule

Benefits are available In-Network and Out-of-Network.

Employer's Name: Southeast Restaurants Corp.

Client Number: 59999

Client Effective Date: January 1, 2019

Group Number: 66-17502-01

Anniversary Date: January 1

Coverage Effective Date: January 1, 2020

Benefit Period: January 1st thru December 31st

DEDUCTIBLE

Network Providers – $2,500 per Member per Benefit Period and $5,000 per family per Benefit Period. With family coverage, once one Member meets a $2,500 Deductible, benefits will begin paying for that Member.

Out-of-Network Provider – $5,000 per Member or $10,000 per Family per Benefit Period.

The In-Network and Out-of-Network amounts do not apply to each other. The Deductible applies to the Maximum Out-of-Pocket.

The Deductible applies to all Covered Services except Preventive Care and Primary Care Physician Office visit when the Copayment applies to that visit. The Deductible applies to the Maximum Out-of-pocket.

COINSURANCE

Network Providers – The Percentage of the Allowed Amount that you pay for Covered Services. You pay 20% of the Allowed Amount until you reach the Maximum Out-of-pocket.

Out-of-Network Providers – You pay 40% of the Allowed Amount.

COPAYMENTS

- $40 per Primary Care Physician (PCP)* Office Visit including Doctors Care
- $30 per Blue CareOnDemandSM Visit
- $65 per Specialist* Office Visit
- $65 per Urgent Care Center Visit
- $300 per Emergency Room (ER) Visit subject to Deductible and Coinsurance
- $500 per Inpatient Hospital Services Visit subject to Deductible and Coinsurance

Copayments apply toward the Maximum Out-of-pocket and stops when the Maximum Out-of-pocket is reached. Copayments do not apply to the Deductible.

MAXIMUM OUT-OF-POCKET

Network Providers – $7,000 per Member per Benefit Period and $14,000 per family per Benefit Period Covered Services will be paid at 100% of the Allowable Charges when you reach your Maximum Out-of-pocket. With family coverage, once one Member meets a $7,000 Maximum Out-of-Pocket, benefits are payable at 100% for that Member only.

Out-of-Network Providers – $14,000 per member or $28,000 Family per Benefit Period.

The In-Network and Out-of-Network amounts do not apply to each other. Covered Service will be paid at 100% from Network Providers after the Out-of-Pocket Limit is met.

The Maximum Out-of-pocket includes Copayments, Deductibles and Coinsurance. It does not include Premiums, Balance-billed charges or health care this Policy does not cover.

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

PRESCRIPTION DRUG COVERAGE

In-Network Retail: 31 days supply maximum

Tier 0: $0 Copayment

Tier 1: $8 Copayment

Tier 2: Prescription Drug Deductible then $35 Copayment

Tier 3: Prescription Drug Deductible then $70 Copayment

Tier 4: 20% up to $500 after Prescription Drug Deductible

Out-of-Network Retail:

Tier 0: No Benefits

Tier 1/2/3: In-Network Copayment then 40% coinsurance

Tier 4: No Benefits

In-Network Retail Mail-Order: 90 day supply

Tier 0: $0 Copayment

Tier 1: $16 Copayment

Tier 2: Prescription Drug Deductible then $80.50 Copayment

Tier 3: Prescription Drug Deductible then $161 Copayment

Tier 4: No Benefits

Out-of-Network Retail: No Benefits for Out-of-Network Mail-Order pharmacy.

Some drugs are considered specialty medications and must be filled at our Specialty Pharmacy, BriovaRx®. Although most specialty drugs are found in Tier 4, they could be Tier 1, 2 or 3. Please see your Certificate for a description of the Tiers for further clarification. Also see the Business BlueEssentials Covered Drug List for the list of drugs that must be filled with the Specialty Pharmacy.

$500 Prescription Drug Deductible per Member per Benefit Period for Tiers 2, 3 and 4 Prescription Drugs.

BENEFIT PERIOD MAXIMUM — Per Member Per Benefit Period

60 days for Skilled Nursing Facility

60 visits for Home Health Care

6 months per episode for Inpatient and Outpatient Hospice Care

30 Rehabilitative visits for Physical, Speech and Occupational Therapy Services combined

30 Habilitative visits for Physical, Speech and Occupational Therapy Services combined

$500 Sustained Health Benefit for physical exam services not included in other Preventive Screenings

All benefits payable on Covered Services are based on our allowed amount. All covered services must be medically necessary. Some services require preauthorization, including all hospital admissions, except maternity. See the preauthorization section of the Certificate for information concerning the preauthorization requirement.

For some services to be covered, you will be required to use a provider we designate, who may or may not be a Business BlueEssentials provider. These services include transplants, mammography, habilitation, rehabilitation and vision care.

Our plan has free language interpretation services available. We can also give you information in languages other than English, in large print or other alternate formats.

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

Services That Are Covered For You

PRIMARY CARE PHYSICIAN, SPECIALIST OR URGENT CARE CENTERS

	In-Network	Out-of-Network
Office Visit Services – Office charges for the treatment of an illness, accident or injury; injections for allergy, tetanus and antibiotics; diagnostic lab and diagnostic X-ray services (such as chest X-rays and standard plain film X- rays), when performed in the physician's office on the same date and billed by the physician (excluding maternity). Includes mental health and substance use disorder services.	0% after Copayment	40% after Deductible
Blue CareOnDemand℠	0% after Copayment	40% after Deductible
Inpatient Physician and Surgical Services	20% after Deductible	40% after Deductible
All Other Physician Services – Outpatient hospital; skilled nursing facility; clinics; lab, X-ray, and the reading/interpretation of diagnostic lab and X-ray services; surgery, male sterilization; second surgical opinion; consultation; anesthesia; dialysis treatment, chemotherapy, radiation therapy and the administration of specialty medications.	20% after Deductible	40% after Deductible
Urgent Care Center – The facility must be licensed as an urgent care center.	0% after Copayment	40% after Deductible

PREVENTIVE CARE FOR CHILDREN AND ADULTS

	In-Network	Out-of-Network
As outlined in your Contract as Preventive Care benefits. Includes some contraceptive devices or services. There are No Benefits for Preventive Care Out-of-Network.	$0	**No Benefits**
All other covered contraceptive devices or services not specifically listed in your Contract.	20% after Deductible	40% after Deductible
Services related to a physical exam not included in other covered Preventive Screenings limited to $500 per Benefit Period. Services may be subject to age and visit limits. There are No Benefits for Sustained Health Out-of-Network.	$0	**No Benefits**

LABORATORY AND DIAGNOSTIC SERVICES

	In-Network	Out-of-Network
Radiology, ultrasound and nuclear medicine; laboratory and pathology; ECG, EEG and other electronic diagnostic medical procedures and physiological medical testing; Endoscopies (such as colonoscopy, proctoscopy and laparoscopy); high technology diagnostic services such as, but not limited to, MRIs, MRAs, PET scans, CT scans, cardiac catheterizations and procedures performed with contrast or dye.	0% at Independent Laboratory 20% after Deductible at Outpatient Facility	40% after Deductible

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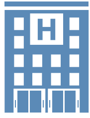
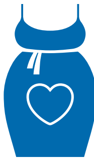


HOSPITAL SERVICES

	In-Network	Out-of-Network
Inpatient and outpatient Hospital (other than Skilled Nursing Facilities, Rehabilitation Facilities or Emergency Room). Includes Mental Health and Substance Use Disorder Services.	20% after Copayment then Deductible	40% after Deductible
Ambulatory Surgical Center (ASC) facility charge - An ASC is a free-standing facility not affiliated with a health system that is licensed for Outpatient Services only and doesn't provide overnight accommodations or around-the-clock care.	20% after Deductible	40% after Deductible

EMERGENCY SERVICES

	In-Network	Out-of-Network
Emergency room charges in- or out-of-network or out-of-area, including physician services in the Emergency Room (copayment applies only to Emergency Room charges)	20% after Copayment then Deductible	20% after Copayment then Deductible
Ambulance services in- or out-of-network or out-of-area, only when medically necessary	20% after Deductible	40% after Deductible



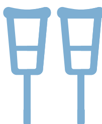
MATERNITY

	In-Network	Out-of-Network
Pre- and post-partum care including Physician services. Hospital services provided as shown above.	20% after Deductible	40% after Deductible

Expecting a new baby? Our free Maternity Care program can provide you with the tools and information you need to help get your baby off to a healthy start. To enroll, call 855-838-5897 and select option 4.

NEWBORN CARE

	In-Network	Out-of-Network
Post-natal care, including physician services. Hospital services provided as shown above. Benefits are available only if the child is added to your policy.	20% after Deductible	40% after Deductible



REHABILITATIVE AND HABILITATIVE

	In-Network	Out-of-Network
Durable Medical Equipment (DME) - purchase or rental - excludes repair of, replacement of and duplicate DME. There are no Out-of-Network benefits for DME	20% after Deductible	**No Benefits**
Physical, occupational, speech and respiratory therapy	20% after Deductible	40% after Deductible
Rehabilitation including cardiac and pulmonary	20% after Deductible	40% after Deductible
Skilled nursing and rehabilitation facilities	20% after Deductible	40% after Deductible
Medical supplies	20% after Deductible	40% after Deductible

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MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES

	In-Network	Out-of-Network
Inpatient and physician's services	20% after Copayment then Deductible	40% after Deductible
Outpatient and physician's services	20% after Deductible	40% after Deductible
Residential treatment centers	20% after Deductible	40% after Deductible
Physician's office (same as Primary Care Physician (PCP) Office visit)	0% after Copayment	40% after Deductible
Autsim Spectrum Disorder - Behavioral Therapy. Preauthorization is required	20% after Deductible	No Benefits

OTHER SERVICES

	In-Network	Out-of-Network
Dental Services Related to Accidental Injury – Only when such care is for treatment, Surgery or appliances caused by accidental bodily injury (except dental injuries occurring through the natural act of chewing). It's limited to care completed within six months of such accident and while the patient is still covered under this policy.	20% after Deductible	40% after Deductible
Home health care (60-visit maximum)	20% after Deductible	40% after Deductible
Hospice care (6 months per episode to include Inpatient and Outpatient care)	20% after Deductible	40% after Deductible
Out-of-Country services including facility and physician for emergency and urgent care only, if covered through a BlueCard® provider.	20% after Deductible	40% after Deductible

South Carolina

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