South Carolina

**BlueEssentials Gold 5**

**Coverage Period: 1/1/2027 – 12/31/2027**
**Coverage for:** Individual-Family | **Plan Type:** EPO

**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 1-855-404-6752 to request a copy or go to www.SouthCarolinaBlues.com/links/policies. 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 call 1-855-404-6752 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$250/individual and $500/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. 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. $1,000/individual and $2,000/family 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 out-of-pocket limit for this plan?** | **$12,000/individual and $24,000/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. | 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. For a list of in-network providers, see http://www.southcarolinablues.com/en/provider-directory/2027/blueessentials 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 **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 |
|---|---|---|---|---|
| | | 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 | $20 copay/visit Deductible does not apply | Not covered | Copay doesn't include surgery, outpatient lab & 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 | $40 copay/visit Deductible does not apply | Not covered | |
| | Preventive care/screening/immunization | No charge | Not covered | Must use network provider. 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) | 50% coinsurance | Not covered | NONE |
| | Imaging (CT/PET scans, MRIs) | 50% coinsurance | Not covered | No benefits if not preapproved. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at https://www.southcarolinablues.com/links/pharmacy/Individual | Generic (Tier 1) | $10 (retail)/$14 (mail-order) copay/prescription Deductible does not apply | Not covered | 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, Optum RX Specialty Services.<br>$1,000/individual and $2,000/family 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, Optum RX Specialty Services. |
| | Preferred (Tier 2) | $40 (retail)/$108 (mail-order) copay/prescription Deductible does not apply | Not covered | |
| | Non-Preferred (Tier 3) | 50% after the Prescription Drug Deductible | Not covered | |
| | Specialty Drug (Tier 4) | 50% after the Prescription Drug Deductible | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 50% coinsurance | Not covered | Preauthorization may be required. $500 Copayment per Ambulatory Surgery Center facility charge. $200 Copayment for Pediatric Tympanostomy performed at a facility that is a designated Center of Excellence (COE). |
| | Physician/surgeon fees | 50% coinsurance | Not covered | Preauthorization may be required. |

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

| 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 need immediate medical attention** | Emergency room care | 50% coinsurance | 50% coinsurance | NONE |
| | Emergency medical transportation | 50% coinsurance | Not covered | |
| | Urgent care | $40 copay/visit Deductible does not apply | Not covered | Copay doesn't include surgery, outpatient lab & X-ray services (except for standard plain film X-rays), second surgical opinion, dialysis, chemotherapy, radiation therapy, administration of specialty drugs, endoscopies and imaging. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 50% coinsurance | Not covered | No benefits if not preapproved. No benefits for human organ/tissue transplant if not preapproved and at designated provider. |
| | Physician/surgeon fee | 50% coinsurance | Not covered | No benefits for human organ/tissue transplant if not preapproved and at designated provider. |
| **If you have mental health, behavioral health, or substance abuse services** | Outpatient services | 50% coinsurance | Not covered | $20 copay/visit for in-network office visit. No benefits for psychological testing, repetitive Transcranial Magnetic Stimulation, intensive outpatient services, partial hospitalization and electroconvulsive therapy if not preapproved. |
| | Inpatient services | 50% coinsurance | Not covered | No benefits if not preapproved. |

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| 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 are pregnant** | Office visits | 50% coinsurance | Not covered | $20 copay/initial visit only. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery professional services | 50% coinsurance | Not covered | Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery facility services | 50% coinsurance | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | 50% coinsurance | Not covered | Limited to 60 visits/year. No benefits if not preapproved. |
| | Rehabilitation services | 50% coinsurance | Not covered | Physical, occupational and speech therapy limited to 30 Rehabilitative visits/year combined. No inpatient benefits if not preapproved. |
| | Habilitation services | 50% coinsurance | Not covered | Physical, occupational and speech therapy limited to 30 Habilitative visits/year combined. No inpatient benefits if not preapproved. |
| | Skilled nursing care | 50% coinsurance | Not covered | Limited to 60 days/year. No benefits if not preapproved. |
| | Durable medical equipment | 50% coinsurance | Not covered | No benefits if not preapproved. |
| | Hospice service | 50% coinsurance | Not covered | Limited to 6 months/episode. No benefits if not preapproved. |
| **If your child needs dental or eye care** | Children's eye exam | $0 copay Deductible does not apply | Not covered | Limited to one exam per benefit period. |
| | Children's glasses | $0 copay Deductible does not apply | Not covered | Limited to once per benefit period for frames and lenses. |
| | Children's dental check-up | Not covered | Not covered | NONE |

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

## 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.) | | |
|---|---|---|
| • Abortion Services* | • Dental care (Adult) | • Residential and custodial care |
| • Acupuncture | • Hearing aids | • Routine eye care (Adult) |
| • Bariatric Surgery | • Infertility treatment | • Routine foot care |
| • Children's dental check-up | • Long-term care | • Weight loss programs |
| • Chiropractic Care | • Non-emergency care when traveling outside the U.S. | |
| • Cosmetic Surgery | • Private Duty Nursing | |

***Abortion services (except in cases of rape, incest, or when the life of the mother is endangered)**

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

## 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 at 1-803-737-6160 or www.doi.sc.gov, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services 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 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 1-855-404-6752 or visit http://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 Department of Insurance customer assistance at: 1-800-768-3467 or visit www.doi.sc.gov.

## 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 Standard? **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.

*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** **$250**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **50%**
- **Other coinsurance** **50%**

**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* | $250 |
| Copayments | $10 |
| Coinsurance | $6,200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$6,520** |

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

- **The plan's overall deductible** **$250**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **50%**
- **Other coinsurance** **50%**

**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* | $1,250 |
| Copayments | $400 |
| Coinsurance | $1,400 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$3,070** |

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

- **The plan's overall deductible** **$250**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **50%**
- **Other coinsurance** **50%**

**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* | $250 |
| Copayments | $100 |
| Coinsurance | $1,100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,450** |

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