**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 1-800-815-3314. 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 / www.tccba.com or call 1-800-815-3314 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For network providers+$750 individual / $1,500 family. | 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 and physician 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 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?** | For network providers<br>$2,750 medical/individual<br>$3,850 pharmacy/individual<br>$5,500 medical/family<br>$7,700 pharmacy/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?** | Copayments for certain services, premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services. | 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.tompbenefits.comm or call 1-800-815-3314 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. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Do you need a referral to see a specialist?** | **No.** | You can see 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 | $0 copayment/visit for Paladina Health Doctor; $100 copayment/visit | $100 copayment/visit | Non-network providers may balance bill. |
| | Specialist visit | $25 copayment/visit | $25 copayment/visit | Non-network providers may balance bill. |
| | Preventive care/screening/ immunization | No charge | No charge | Non-network providers may balance bill. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% coinsurance | 30% coinsurance | Non-network providers may balance bill. |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | 30% coinsurance | Non-network providers may balance bill. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.scriptcare.com or by calling their Customer Service Department 1-800-880-9988 | Generic drugs | $7 copayment/ prescription retail $14 copayment/mail order | Reduced coverage call Pharmacy Provider for details. | Covers up to a 31-day supply (retail subscription); 90 day supply (mail order prescription). Mandatory Generic Drug Program, see plan document for details. |
| | Preferred brand drugs | $35 copayment/ prescription retail $70 copayment/ mail order | Reduced coverage call Pharmacy Provider for details. | |
| | Non-preferred brand drugs | $50 copayment/ prescription retail $100 copayment/mail order | Reduced coverage call Pharmacy Provider for details. | |
| | Specialty drugs | $250 copayment/ prescription retail | Reduced coverage call Pharmacy Provider for details. | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | 30% coinsurance | Non-network providers may balance bill. |

| 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) | |
| | Physician/surgeon fees | 30% coinsurance | 30% coinsurance | Non-network providers may balance bill. |
| **If you need immediate medical attention** | Emergency room care | No Charge for life threatening;<br>50% coinsurance for non-life threatening | No Charge for life threatening;<br>50% coinsurance for non-life threatening | Non-network providers may balance bill. |
| | Emergency medical transportation | No Charge for life threatening;<br>50% coinsurance for non-life threatening | No Charge for life threatening;<br>50% coinsurance for non-life threatening | Non-network providers may balance bill. |
| | Urgent care | $100 copayment/visit | $100 copayment/visit | Non-network providers may balance bill. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance after deductible | 30% coinsurance after deductible | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the allowable charge.<br>Providers may balance bill. |
| | Physician/surgeon fees | 30% coinsurance after deductible | 30% coinsurance after deductible | Providers may balance bill. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copayment/visit | $25 copayment/visit | Non-network providers may balance bill. |
| | Inpatient services | 30% coinsurance after deductible | 30% coinsurance after deductible | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the allowable charge.<br>Non-network providersmay balance bill. |
| **If you are pregnant** | Office visits | $0 copayment/ visit routine;<br>$25 copayment/ sick visit | $0 copayment/ visit routine;<br>$25 copayment/ sick visit | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).<br><br>Non-network providers may balance bill.<br><br>Preauthorization is required for all inpatient services. If you don't get preauthorization, benefits could be reduced by 50% of the |
| | Childbirth/delivery professional services | 30% coinsurance after deductible | 30% coinsurance after deductible | |
| | Childbirth/delivery facility services | 30% coinsurance after deductible | 30% coinsurance after deductible | |

| 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) | |
| | | | | allowable charge. |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance after deductible | 30% coinsurance after deductible | 60 visits per calendar year. Non-network providers may balance bill. |
| | Rehabilitation services | 30% coinsurance | 30% coinsurance | Non-network providers may balance bill. |
| | Habilitation services | 30% coinsurance after deductible | 30% coinsurance | Non-network providers may balance bill. |
| | Skilled nursing care | 30% coinsurance after deductible | 30% coinsurance after deductible | 60 days per calendar year. Non-network providers may balance bill. |
| | Durable medical equipment | 30% coinsurance after deductible | 30% coinsurance after deductible | Preauthorization is required if over $2,000. If you don't get preauthorization, benefits could be reduced by 50% of the allowable charge. Non-network providers may balance bill. |
| | Hospice services | 30% coinsurance after deductible | 30% coinsurance after deductible | Preauthorization is required for all inpatient services. If you don't get preauthorization, benefits could be reduced by 50% of the allowable charge. Non-network providers may balance bill. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | Refer to Vision Service Plan (VSP) |
| | Children's glasses | Not covered | Not covered | Refer to Vision Service Plan (VSP) |
| | Children's dental check-up | Not covered | Not covered | Refer to Town of Mount Pleasant's Dental Plan |

## 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 (if prescribed by a physician for rehabilitation purposes)
- Bariatric Surgery
- Cosmetic Surgery
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care

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

- Chiropractic Care
- **Dental Care**
- 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: 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 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: Thomas H. Cooper & Co., Inc. at 1-800-815-3314 or www.tccba.com. You may also contact your state insurance department at South Carolina Department of Insurance at 1-803-737-6160 or http://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 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 (Español): Para obtener asistencia en Español, llame al 1-800-815-3314.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-815-3314.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[ 1-800-815-3314.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-815-3314.]

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



**About these Coverage Examples:**

[* For more information about limitations and exceptions, see the plan or policy document at / www.tccba.com or call 1-800-815-3314 to request a copy.]

**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** **$750**
- **Specialist copayment** **$25**
- **Hospital (facility)** coinsurance and deductible 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 | $750 |
| Copayments | $30 |
| Coinsurance | $2,000 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,810** |

## Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$25**
- **Hospital (facility)** coinsurance and deductible 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 | $750 |
| Copayments | $600 |
| Coinsurance | $50 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,420** |

## Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$25**
- **Hospital (facility)** coinsurance and deductible 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 | $750 |
| Copayments | $80 |
| Coinsurance | $10 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$840** |

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).

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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)

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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)

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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)

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

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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)

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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)

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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)

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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)

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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)

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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)

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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)

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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)

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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)

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اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی 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 شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

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