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 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 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 preferred providers $750individual / $1,500 family; for non-preferred provider $1,500 individual / $3,000 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.
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 preferred providers $3,000 individual / $6,000 family; for non-preferred provider $6,000 individual / $12,000 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?	Copayments for certain services, deductible, 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 preferred provider?	Yes. See www.tccba.com or call 1-800-815-3314 for a list of preferred 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 non-preferred 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 preferred provider might use an non-preferred 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
		Preferred Provider (You will pay the least)	Non-Preferred 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	$25 copay/visit	40% coinsurance	None
	Specialist visit	$25 copay/visit	40% coinsurance	None
	Preventive care/screening/ immunization	$25 copay/visit	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the allowable charge.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.tccba.com	Generic drugs (Tier 1)	$5 copay/prescription retail	Not covered	Covers up to a 60-day supply (retail subscription) Specialty Drugs covered at same tier copays based on drug classification
	Preferred brand drugs (Tier 2)	$35 copay/prescription retail	Not covered	
	Non-preferred brand drugs (Tier 3)	$45 copay/prescription retail	Not covered	
	Specialty drugs (Tier 4)	Covered	Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	None
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	Deductible waived for treatment received within 72 hours of an accident or the sudden on-set of life threatening symptoms.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	None
	Urgent care	$50 copay/visit	$50 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the allowable charge.
	Physician/surgeon fees	20% coinsurance after	40% coinsurance after	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
		deductible	deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit	40% coinsurance after deductible	None
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the allowable charge.
If you are pregnant	Office visits	$25 copay/visit	40% coinsurance after deductible	Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). .
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	100 visits per calendar year
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	40 visits per Calendar Year; Pre-authorization required after 12 visits
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	40 visits per Calendar Year; Pre-authorization required after 12 visits
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	60 days per calendar year
	Durable medical equipment	20% coinsurance after deductible	Not covered	Preauthorization is required if over $2,000. If you don't get preauthorization, benefits could be reduced by 50% of the allowable charge.
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	None
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 Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Routine Foot Care
- Weight Loss Programs

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

- Private Duty Nursing

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: The plan at 1-843-722-2215, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, South Carolina Department of Insurance at 1-803-737-6160 or http://doi.sc.gov. Additionally, a consumer assistance program can help you file your appeal contact 800-768-3467 or http://doi.sc.gov/consumers

Does this plan 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 plan meet 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，☒☒打☒个号☒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:

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	20%
■ Other coinsurance and deductible	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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$150
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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	20%
■ Other coinsurance and deductible	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*	$750
Copayments	$960
Coinsurance	$370
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,135**

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	20%
■ Other coinsurance and deductible	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*	$750
Copayments	$80
Coinsurance	$325
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,155**

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