**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, visit peba.sc.gov or call 888.260.9430. 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 888.260.9430 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $515 individual<br>$1,030 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 | 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 www.PEBAperks.com. |
| **Are there other deductibles for specific services?** | Yes. $15 for physician office or video visit; $193 for emergency care; $115 for outpatient facility services. | 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?** | For network providers $3,000 individual / $6,000 family; for out-of-network providers $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?** | Premiums, copayments, penalties for failure to get preauthorization for services, specific service deductibles 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. See www.peba.sc.gov or call 888.260.9430 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 a specialist you choose without a referral by the plan. |

⚠ 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 | $15 copay/office visit then 20% coinsurance | $15 copay/office visit then 40% coinsurance | In-network Patient-Centered Medical Home in-person visits subject to $0 copay and 10% coinsurance. |
| | Specialist visit | $15 copay/office visit then 20% coinsurance | $15 copay/office visit then 40% coinsurance | None |
| | Preventive care/screening/ immunization | No charge for routine mammograms. No charge for adult well visits, well woman visits, well child care visits, including immunizations, adult immunizations, routine colonoscopy and contraceptives. For more details, see www.peba.sc.gov. | No charge for routine Pap test (subject to balance bill). No other preventive services covered out of network. | Pap test benefit is limited to one per calendar year and for the human papillomavirus (HPV) test every five years for women ages 18-65. One baseline mammogram will be covered for women ages 35-39. One routine mammogram will be covered each calendar year for women ages 40 and older. Immunizations are covered at the appropriate ages recommended by the Centers for Disease Control for adults ages 19 and older and for children through age 18. Primary members ages 19 and older may receive an annual adult well visit from a network provider. Annual well visits are limited to USPSTF A and B recommendations. Primary female members ages 19 and older may receive an annual well woman visit from a network provider. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $115 copay/outpatient facility visit, then 20% coinsurance; $15 copay/office visit, then 20% coinsurance | $115 copay/outpatient facility visit, then 40% coinsurance; $15 copay/office visit, then 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | $115 copay/outpatient facility visit, then 20% coinsurance; $15 copay/office visit, then 20% coinsurance | $115 copay/outpatient facility visit, then 40% coinsurance; $15 copay/office visit, then 40% coinsurance | Imaging must be preauthorized by National Imaging Associates. |

[* For more information about limitations and exceptions, see the plan or policy document at peba.sc.gov.

| | | | | |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at peba.sc.gov | Generic drugs | $13 copay/prescription retail; $32 copay/ prescription mail order | Not covered | Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Drugs in FDA Phase I, II or III are not covered. Some drugs may require preauthorization. You pay the difference in price of drug if you request a brand name drug instead of its generic equivalent. |
| | Preferred brand drugs | $46 copay/ prescription retail; $115 copay/ prescription mail order | Not covered | |
| | Non-preferred brand drugs | $77 copay/ prescription retail; $192 copay/ prescription mail order | Not covered | |
| | Specialty drugs | $77 copay/ prescription retail; $192 copay/ prescription mail order; 20% coinsurance under medical benefit for physician-administered specialty drugs | Not covered; 40% coinsurance under medical benefit for physician-administered specialty drugs | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $115 copay/visit, then 20% coinsurance | $115 copay/visit, then 40% coinsurance | Certain services must be preauthorized by Medi-Call or $515 penalty per occurrence. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | Services must be preauthorized by Medi-Call. |
| **If you need immediate medical attention** | Emergency room care | $193 copay/visit, then 20% coinsurance | $193 copay/visit, then 40% coinsurance | Services must be preauthorized by Medi-Call within 48 hours of admission. |
| | Emergency medical transportation | 20% coinsurance | 40% coinsurance | Certain services must be preauthorized by Medi-Call. |
| | Urgent care | $115 copay/visit, then 20% coinsurance | $115 copay/visit, then 40% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Certain services must be preauthorized by Medi-Call or $515 penalty per occurrence. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | Services must be preauthorized by Medi-Call or $515 penalty/occurrence. Benefits are limited to one consultation per consulting physician for each inpatient hospital stay. |

| | | | | |
|---|---|---|---|---|
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $15 copay/office visit, then 20% coinsurance | $15 copay/office visit, then 40% coinsurance | Applied Behavior Analysis Therapy and Psychological/Neuropsychological Testing must be preauthorized by Companion Benefit Alternatives. |
| | Inpatient services | 20% coinsurance | 40% coinsurance | Services must be preauthorized by Companion Benefit Alternatives. |
| **If you are pregnant** | Office visits | $15 copay/office visit, then 20% coinsurance | $15 copay/office visit, then 40% coinsurance | Services must be preauthorized by Medi-Call. Covered children do not have maternity benefits. |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | Services must be preauthorized by Medi-Call. Benefits are limited to 100 visits per year. |
| | Rehabilitation services | $15 copay/visit, then 20% coinsurance | $15 copay/visit, then 40% coinsurance | Services must be preauthorized by Medi-Call. Benefits are not payable for vocational rehabilitation intended to teach a patient how to be gainfully employed, cognitive retraining, community re-entry programs, long-term rehabilitation, services by a massage therapist or work-hardening programs. |
| | Habilitation services | $15 copay/visit, then 20% coinsurance | $15 copay/visit, then 40% coinsurance | Habilitative services related to speech therapy are covered through age 6. |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Services must be preauthorized by Medi-Call. Benefits limited to 60 days. Physician visits limited to one per day. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Purchase or rental of equipment must be preauthorized by Medi-Call. |
| | Hospice services | 20% coinsurance | 40% coinsurance | Services must be preauthorized by Medi-Call. Benefits are limited to 80 days for a patient certified by his physician as having a terminal illness and a life expectancy of six months or less. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | Coverage provided under separate vision plan. |
| | Children's glasses | Not covered | Not covered | Coverage provided under separate vision plan. |
| | Children's dental check-up | No covered | Not covered | Coverage provided under separate dental plan. |

## Excluded Services & Other Covered Services:

[* For more information about limitations and exceptions, see the plan or policy document at peba.sc.gov.

| 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 | • Hearing aids | • Routine eye care (adult) |
| • Bariatric surgery | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Private-duty nursing | • Weight loss |
| • Dental care (adult) | | |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Chiropractic care | • Infertility treatment | • Care when traveling outside the U.S. |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact PEBA at 888.260.9430. 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 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 on how 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 PEBA at 888.260.9430 or the Department of Labor's Employee Benefits Security Administration at 866.444.EBSA (3272) or www.dol.gov/ebsa/healthreform. For grievances and appeals regarding your prescription drug coverage, call the number on the back of your prescription benefit card.

**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 888.260.9430.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888.260.9430.

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 888.260.9430.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888.260.9430.

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



[* For more information about limitations and exceptions, see the plan or policy document at peba.sc.gov.

## 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 prenatal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $515 |
| Specialist *[cost sharing]* | $15 |
| Hospital (facility) *[cost sharing]* | 20% |
| Other *[cost sharing]* | 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** | **$9,730** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $10 |
| Coinsurance | $2,400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,970** |

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

| | |
|---|---|
| The plan's overall deductible | $515 |
| Specialist *[cost sharing]* | $15 |
| Hospital (facility) *[cost sharing]* | 20% |
| Other *[cost sharing]* | 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** | **$4,280** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $400 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,320** |

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

| | |
|---|---|
| The plan's overall deductible | $515 |
| Specialist *[cost sharing]* | $15 |
| Hospital (facility) *[cost sharing]* | 20% |
| Other *[cost sharing]* | 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** | **$1,790** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $10 |
| Coinsurance | $500 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,010** |

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