This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.peba.sc.gov or by calling 1.888.260.9430.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$445** individual / **$890** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$159** for emergency care. **$95** for outpatient facility services. **$12** for physician office visit.	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.
Is there an out–of–pocket limit on my expenses?	Yes. For network providers **$2,540** individual / **$5,080** family; for out-of-network providers **$5,080**individual / **$10,160** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, co-payments, penalties for failure to obtain preauthorization for services, specific service deductibles, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of network providers, see www.peba.sc.gov or call 1.888.260.9430.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1.888.260.9430 or visit us at www.peba.sc.gov.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1.888.260.9430 to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$12 copay/visit then 20% co-insurance	$12 copay/visit then 40% co-insurance	In-network Patient-Centered Medical Home visits subject to $0 copay and 10% co-insurance
	Specialist visit	$12 copay/visit then 20% co-insurance	$12 copay/visit then 40% co-insurance	——none——
	Other practitioner office visit	$12 copay/visit then 20% co-insurance	$12 copay/visit then 40% co-insurance	Chiropractic payments limited to **$2,000** a year per person. No benefits for acupuncture.
	Preventive care/screening/immunization	No charge for routine Pap test lab fee or mammograms lab fees; office visits not covered. No charge for well child care visits, including immunizations, adult immunizations, routine colonoscopy, and contraceptives for employee/spouse. For details about more preventive benefits, 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 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 40-74. Immunizations are covered at the appropriate ages recommended by the Centers for Disease Control for children through age 18. Immunizations are generally not covered unless listed.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	$95 copay/visit to outpatient facility then 20% co-insurance; $12 copay/visit to office then 20% co-insurance	$95 copay/visit to outpatient facility then 40% co-insurance; $12 copay/visit to office then 40% co-insurance	none
	Imaging (CT/PET scans, MRIs)	$95 copay/visit to outpatient facility then 20% co-insurance; $12 copay/visit to office then 20% co-insurance	$95 copay/visit to outpatient facility then 40% co-insurance; $12 copay/visit to office then 40% co-insurance	Imaging must be preauthorized by National Imaging Associates.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.eip.sc.gov.	Generic drugs	$9 copay/ prescription retail; $22 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	$38 copay/ prescription retail; $95 copay/ prescription mail order	Not Covered	
	Non-preferred brand drugs	$63 copay/ prescription retail; $158 copay/ prescription mail order	Not Covered	
	Specialty drugs	$63 copay/ prescription retail; $158 copay/ prescription mail order	Not Covered	

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$95 copay/visit then 20% co-insurance	$95 copay/visit then 40% co-insurance	Services must be preauthorized by Medi-Call.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	Services must be preauthorized by Medi-Call.
If you need immediate medical attention	Emergency room services	$159 copay/visit then 20% co-insurance	$159 copay/visit then 40% co-insurance	Services must be preauthorized by Medi-Call within 48 hours of admission.
	Emergency medical transportation	20% co-insurance	40% co-insurance and balance bill	Services must be preauthorized by Medi-Call.
	Urgent care	$95 copay/visit then 20% co-insurance	$95 copay/visit then 40% co-insurance	none
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Services must be preauthorized by Medi-Call.
	Physician/surgeon fee	20% co-insurance	40% co-insurance	Services must be preauthorized by Medi-Call. Benefits are limited to one consultation per consulting physician for each inpatient hospital stay.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$12 copay/visit then 20% co-insurance	$12 copay/visit then 40% co-insurance	Applied Behavior Analysis Therapy and Psychological/Neuropsychological Testing must be preauthorized by Companion Benefit Alternatives.
	Mental/Behavioral health inpatient services	$12 copay/visit then 20% co-insurance	$12 copay/visit then 40% co-insurance	Services must be preauthorized by Companion Benefit Alternatives.
	Substance use disorder outpatient services	$12 copay/visit then 20% co-insurance	$12 copay/visit then 40% co-insurance	Services must be preauthorized by Companion Benefit Alternatives.
	Substance use disorder inpatient services	$12 copay/visit then 20% co-insurance	$12 copay/visit then 40% co-insurance	Services must be preauthorized by Companion Benefit Alternatives.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	$12 copay/visit then 40% co-insurance	Services must be preauthorized by Medi-Call within the first trimester of the pregnancy. Covered children do not have maternity benefits.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	Services must be preauthorized by Medi-Call. Covered children do not have maternity benefits.
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Services must be preauthorized by Medi-Call. Benefits are limited to 100 visits per year.
	Rehabilitation services	20% co-insurance	40% co-insurance	Services must be preauthorized by Medi-Call. Benefits are not payable for vocational rehabilitation intended to teach a patient how to be gainfully employed, pulmonary rehabilitation (except in conjunction with a lung transplant), cognitive retraining, community re-enty programs, long-term rehabilitation, or work-hardening programs.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	20% co-insurance	40% co-insurance	Services must be preauthorized by Medi-Call. Benefits limited to 60 days. Physician visits limited to one per day.
	Durable medical equipment	20% co-insurance	40% co-insurance	Purchase or rental of equipment must be preauthorized by Medi-Call.
	Hospice service	20% co-insurance	40% co-insurance	Services must be preauthorized by Medi-Call. Benefits are limited to $6,000 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	Eye exam	Not Covered	Not Covered	Not Covered
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Infertility treatment
- Care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-888-260-9430. You may also contact your state insurance department, the 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: PEBA at 1-888-260-9430 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-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 or visit www.express-scripts.com.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,5533
- **Patient pays** $2,007

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$445
Co-pays	$12
Co-insurance	$1,360
Limits or exclusions	$190
Total	**$2,007**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,160
- **Plan pays** $3,965
- **Patient pays** $1,195

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$60
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,160**

Patient pays:

Deductibles	$445
Co-pays	$360
Co-insurance	$390
Limits or exclusions	$0
Total	**$1,195**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

PEBA considers the SHP to be a "grandfathered health plan" under the ACA. As such, PEBA will minimize the increase in premiums while it assesses the future financial impact of the act. A grandfathered plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered means that the plan may not include certain consumer protections of the ACA that apply to other plans; however, grandfathered health plans must comply with certain other consumer protections in the ACA.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.peba.sc.gov or by calling 1.888.260.9430.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,600** individual **/$7,200** family If you participate in your employer's HRA, it will pay for qualified medical expenses up to the balance available.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For network providers **$2,400** individual **/ $4,800** family; for out-of-network providers **$4,800** individual **/ $9,600** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, co-payments, penalties for failure to obtain preauthorization for services, specific service deductibles, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of network providers, see www.peba.sc.gov or call 1.888.260.9430.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1.888.260.9430 or visit us at www.peba.sc.gov.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1.888.260.9430 to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	40% co-insurance	In-network Patient-Centered Medical Home visits subject to 10% co-insurance
	Specialist visit	20% co-insurance	40% co-insurance	—none—
	Other practitioner office visit	20% co-insurance	40% co-insurance	Chiropractic payments limited to **$500** a year per person. No benefits for acupuncture.
	Preventive care/screening/immunization	No charge for routine Pap test lab fee or mammograms lab fees; office visits not covered. No charge for well child care visits, including immunizations, adult immunizations, annual physical routine colonoscopy, and contraceptives for employee/spouse. For details about more preventive benefits, 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 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 40-74. Immunizations are covered at the appropriate ages recommended by the Centers for Disease Control for children through age 18. Subscribers age 19 and older may receive an annual physical only from a network provider. Immunizations are generally not covered unless listed.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	none
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	Imaging must be preauthorized by National Imaging Associates.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.eip.sc.gov.	Generic drugs	Subscriber pays the State Health Plan's allowed amount until the annual deductible is met. Afterward, the subscriber will be reimbursed 80%. When coinsurance maximum is reached, the plan will reimburse 100% of the allowed amount.	Not Covered	Participating pharmacies and mail order only. 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		Not Covered	
	Non-preferred brand drugs		Not Covered	
	Specialty drugs		Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	Services must be preauthorized by Medi-Call.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	Services must be preauthorized by Medi-Call.
If you need immediate medical attention	Emergency room services	20% co-insurance	40% co-insurance	Services must be preauthorized by Medi-Call within 48 hours of admission.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
	Emergency medical transportation	20% co-insurance	40% co-insurance and balance bill	Services must be preauthorized by Medi-Call.
	Urgent care	20% co-insurance	40% co-insurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Services must be preauthorized by Medi-Call.
	Physician/surgeon fee	20% co-insurance	40% co-insurance	Services must be preauthorized by Medi-Call. Benefits are limited to one consultation per consulting physician for each inpatient hospital stay.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	40% co-insurance	Applied Behavior Analysis Therapy and Psychological/Neuropsychological Testing must be preauthorized by Companion Benefit Alternatives.
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	Services must be preauthorized by Companion Benefit Alternatives.
	Substance use disorder outpatient services	20% co-insurance	40% co-insurance	Services must be preauthorized by Companion Benefit Alternatives.
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	Services must be preauthorized by Companion Benefit Alternatives.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	40% co-insurance	Services must be preauthorized by Medi-Call within the first trimester of the pregnancy. Covered children do not have maternity benefits.
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	Services must be preauthorized by Medi-Call. Covered children do not have maternity benefits.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Services must be preauthorized by Medi-Call. Benefits are limited to 100 visits per year.
	Rehabilitation services	20% co-insurance	40% co-insurance	Services must be preauthorized by Medi-Call. Benefits are not payable for vocational rehabilitation intended to teach a patient how to be gainfully employed, pulmonary rehabilitation (except in conjunction with a lung transplant), cognitive retraining, community re-enty programs, long-term rehabilitation, services by a message therapist, or work-hardening programs.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	20% co-insurance	40% co-insurance	Services must be preauthorized by Medi-Call. Benefits limited to 60 days. Physician visits limited to one per day.
	Durable medical equipment	20% co-insurance	40% co-insurance	Purchase or rental of equipment must be preauthorized by Medi-Call.
	Hospice service	20% co-insurance	40% co-insurance	Services must be preauthorized by Medi-Call. Benefits are limited to $6,000 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	Eye exam	Not Covered	Not Covered	Not Covered
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See www.peba.sc.gov.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-888-260-9430. You may also contact your state insurance department, the 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: PEBA Insurance Benefits at 1-888-260-9430 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-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 or visit www.medco.com.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,010
- **Patient pays** $4,530

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,600
Co-pays	$0
Co-insurance	$740
Limits or exclusions	$190
Total	**$4,530**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,160
- **Plan pays** $1,230
- **Patient pays** $3,390

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$60
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,160**

Patient pays:

Deductibles	$3,600
Co-pays	$0
Co-insurance	$330
Limits or exclusions	$0
Total	**$3,930**

If you participate in your employer's HRA, the HRA will pay for or reimburse you for certain, qualified medical expenses (including co-pays and coinsurance) for amounts under the deductible, up to the balance available in your HRA.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at https://StateSC.SouthCarolinaBlues.com or by calling 1-800-868-2520.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Tier A $385** individual **/ $770** family; **Tiers B &C $445** individual **/ $890** family. Doesn't apply to Tier A preventive care or Tiers A & B prescriptions. Copays don't count toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Tiers A & B **$6,850** individual **/ $13,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges, health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of network providers, see www.peba.sc.gov or call 1.888.260.9430.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan; however, your **co-payments** and **co-insurance** are reduced if you receive a referral.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-868-2520 or visit us at https://StateSC.SouthCarolinaBlues.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-888-260-9430 to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a(n)			Limitations & Exceptions
		MUSC Health Plan Network (Tier A)	In-network Provider (Tier B)	Out-of-network Provider (Tier C)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay	$12 copay/visit & 20% co-insurance	$12 copay/visit then 40% co-insurance	Tier B: In-network Patient-Centered Medical Home visits subject to $0 copay and 10% co-insurance Chiropractic payments limited to $2,000 a year / person.
	Specialist visit	$45 copay	$12 copay/visit & 20% co-insurance	$12 copay/visit then 40% co-insurance	
	Other practitioner office visit		$12 copay/visit & 20% co-insurance	$12 copay/visit then 40% co-insurance	
	Preventive care / screening /immunization	No charge for services on Preventive A & B lists	Routine Pap test, mammograms, routine colonoscopy, adult immunizations, and well child visits at no charge; rest Not Covered	Routine mammograms and well child visits not covered	————none————
If you have a test	Diagnostic test (x-ray, blood work)	$75 copay/visit x-ray at outpatient facility; $20 copay/visit lab at outpatient facility; if done in-office, physician copay only	$95 copay/visit to outpatient facility then 20% co-insurance; $12 copay/visit to office then 20% co-insurance	$95 copay/visit to outpatient facility then 40% co-insurance; $12 copay/visit to office then 40% co-insurance	————none————

Common Medical Event	Services You May Need	Your cost if you use a(n)			Limitations & Exceptions
		MUSC Health Plan Network (Tier A)	In-network Provider (Tier B)	Out-of-network Provider (Tier C)	
	Imaging (CT/PET scans, MRIs)	$75 copay/visit outpatient facility; $75 copay/office	$95 copay/visit to outpatient facility then 20% co-insurance; $12 copay/visit to office then 20% co-insurance	$95 copay/visit to outpatient facility then 40% co-insurance; $12 copay /visit to office then 40% co-insurance	NIA must preauthorize or not covered.
If you need drugs to treat your illness or condition More information About prescription drug coverage is available at www.eip.sc.gov. **Tier A pricing applies only to MUSC Retail Pharmacies.**	Generic drugs	$6 copay/ prescription retail; $18 copay/ 90-day supply	$9 copay/ prescription retail; $22 copay / prescription mail order	Not Covered	Up to 30-day supply (retail); 31-90 day supply (mail order). FDA Phase I, II, or III Drugs not covered. Some drugs require preauthorization. Pay the difference for a brand name drug if generic available.
	Preferred brand drugs	$30 copay/ prescription retail; $80 copay/ 90-day supply	$38 copay/ prescription retail; $95 copay/ prescription mail order	Not Covered	
	Non-preferred brand drugs & specialty drugs	$50 copay/ prescription retail; $140 copay/ 90-day supply	$63 copay/prescription retail; $158 copay/ prescription mail order	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Major surgery: $265 copay Minor surgery: $75 copay	$95 copay/visit then 20% co-insurance	$95 copay/visit then 40% co-insurance	Medi-Call must preauthorize certain procedures or $200 penalty / occurrence plus loss of coinsurance max
	Physician/surgeon fees	$25 PCP; $45 specialist	20% co-insurance	40% co-insurance	————none————
If you need immediate medical attention	Emergency room services	$159 copay/ visit	$159 copay/visit	$159 copay/visit	$159 waived with hospital admission
	Emergency medical transportation	None; pays under Tier B	20% co-insurance	40% co-insurance and balance bill	————none————

Common Medical Event	Services You May Need	Your cost if you use a(n)			Limitations & Exceptions
		MUSC Health Plan Network (Tier A)	In-network Provider (Tier B)	Out-of-network Provider (Tier C)	
	Urgent care	$75 copay/visit	$95 copay/visit then 20% co-insurance	$95 copay/visit then 40% co-insurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% co-insurance	40% co-insurance	Medi-Call must preauthorize within 48 hours or $200 penalty / admission plus loss of coinsurance max
	Physician/surgeon fee	20% co-insurance	20% co-insurance	40% co-insurance	Medi-Call must preauthorize. Benefits are limited to one consultation per consulting physician for each inpatient hospital stay.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral Health and Substance Abuse Disorder outpatient services	$25 copay professional services; $25 copay outpatient facility	$12 copay/visit then 20% co-insurance	$12 copay/visit then 40% co-insurance	CBA must preauthorize only Applied Behavior Analysis Therapy and Psychological / Neuropsychological Testing.
	Mental/Behavioral Health and Substance Abuse Disorder inpatient services	No facility charge 20% coinsurance professional services	$12 copay/visit then 20% co-insurance	$12 copay/visit then 40% co-insurance	CBA must preauthorize or is Not Covered
If you are pregnant	Prenatal and postnatal care	$25 PCP; $45 specialist	20% co-insurance	40% co-insurance	Medi-Call must preauthorize services within the first trimester of the pregnancy. Covered children do not have maternity benefits.
	Delivery and all inpatient services	No facility charge, 20% co-insurance professional services	20% co-insurance	40% co-insurance	

Common Medical Event	Services You May Need	Your cost if you use a(n)			Limitations & Exceptions
		MUSC Health Plan Network (Tier A)	In-network Provider (Tier B)	Out-of-network Provider (Tier C)	
If you need help recovering or have other special health needs	Home health care	20% co-insurance	20% co-insurance	40% co-insurance	Medi-Call must preauthorize. Benefits limited to 100 visits per year.
	Rehabilitation services	None; pays under Tier B & C	20% co-insurance	40% co-insurance	Medi-Call must preauthorize. Benefits not payable for vocational rehabilitation intended to teach a patient how to be gainfully employed, pulmonary rehabilitation (except in conjunction with lung transplant), cognitive retraining, community re-entry programs, long-term rehabilitation, or work-hardening programs.
	Habilitation services	Not Covered	Not Covered	Not Covered	Not Covered
	Skilled nursing care	None; pays under Tier B & C	20% co-insurance	40% co-insurance	Medi-Call must preauthorize. Benefits limited to 60 days. Physician visits limited to one per day.
	Durable medical equipment	20% co-insurance	20% co-insurance	40% co-insurance	Medi-Call must preauthorize.
	Hospice service	None; pays under Tier B & C	20% co-insurance	40% co-insurance	Medi-Call must preauthorize. Benefits are limited to $6,000 for a patient certified by his physician as having a terminal illness and a life expectancy of six months or less.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Adult dental care
- Hearing aids
- Long-term care
- Private-duty nursing
- Adult eye care & glasses
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See www.peba.sc.gov.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-888-260-9430. You may also contact your state insurance department, the 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: PEBA Insurance Benefits at 1-888-260-9430 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-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 or visit www.medco.com.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

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The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,320
- **Patient pays** $1,220

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$390
Co-pays	$320
Co-insurance	$360
Limits or exclusions	$150
Total	**$1,220**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,030
- **Patient pays** $1,130

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$60
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,160**

Patient pays:

Deductibles	$390
Co-pays	$530
Co-insurance	$210
Limits or exclusions	$0
Total	**$1,130**

Questions and answers about the Coverage Examples:

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Does the Coverage Example predict my own care needs?

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✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

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