



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](http://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](http://www.healthcare.gov/sbc-glossary) or call 888.260.9430 to request a copy.

| Important Questions   | Answers   | Why This Matters:   |
|---|---|---|
| What is the overall <a href="#">deductible</a> ?                                | \$515 individual<br>\$1,030 family  | Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes   | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="http://www.PEBAperks.com">www.PEBAperks.com</a> .  |
| Are there other <a href="#">deductibles</a> 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 <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">network providers</a> \$3,000 individual / \$6,000 family; for <a href="#">out-of-network providers</a> \$6,000 individual / \$12,000 family  | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">copayments</a> , penalties for failure to get preauthorization for services, specific service deductibles and health care this <a href="#">plan</a> doesn't cover. | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.peba.sc.gov">www.peba.sc.gov</a> or call 888.260.9430 for a list of <a href="#">network providers</a> .  | This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No  | You can see a <a href="#">specialist</a> you choose without a <a href="#">referral</a> 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<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)  |  |
| If you visit a health care <a href="#">provider's office or clinic</a> | Primary care visit to treat an injury or illness       | \$15 <a href="#">copay</a> /office visit then 20% <a href="#">coinsurance</a>  | \$15 <a href="#">copay</a> /office visit then 40% <a href="#">coinsurance</a>   | In-network Patient-Centered Medical Home in-person visits subject to \$0 <a href="#">copay</a> and 10% <a href="#">coinsurance</a> .   |
|  | <a href="#">Specialist</a> visit                       | \$15 <a href="#">copay</a> /office visit then 20% <a href="#">coinsurance</a>  | \$15 <a href="#">copay</a> /office visit then 40% <a href="#">coinsurance</a>   | None   |
|  | <a href="#">Preventive care/screening/immunization</a> | No charge for routine Pap test lab fee or mammograms; office visits not covered. No charge for adult well visits, well child care visits, including immunizations, adult immunizations, routine colonoscopy and contraceptives for employee/spouse. For more details, see <a href="http://www.peba.sc.gov">www.peba.sc.gov</a> . | 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 in combination with a Pap test 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. |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | \$115 <a href="#">copay</a> /outpatient facility visit, then 20% <a href="#">coinsurance</a> ; \$15 <a href="#">copay</a> /office visit, then 20% <a href="#">coinsurance</a>  | \$115 <a href="#">copay</a> /outpatient facility visit, then 40% <a href="#">coinsurance</a> ; \$15 <a href="#">copay</a> /office visit, then 40% <a href="#">coinsurance</a> | None   |
|  | Imaging (CT/PET scans, MRIs)                           | \$115 <a href="#">copay</a> /outpatient facility visit, then 20% <a href="#">coinsurance</a> ; \$15 <a href="#">copay</a> /office visit, then 20% <a href="#">coinsurance</a>  | \$115 <a href="#">copay</a> /outpatient facility visit, then 40% <a href="#">coinsurance</a> ; \$15 <a href="#">copay</a> /office visit, then 40% <a href="#">coinsurance</a> | 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](http://peba.sc.gov).

|   |  |   |   |   |
|---|--|---|---|---|
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://peba.sc.gov">peba.sc.gov</a> | Generic drugs                                    | \$13 <a href="#">copay</a> /prescription retail; \$32 <a href="#">copay</a> /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 <a href="#">copay</a> / prescription retail; \$115 <a href="#">copay</a> / prescription mail order   | Not covered   |   |
|   | Non-preferred brand drugs                        | \$77 <a href="#">copay</a> / prescription retail; \$192 <a href="#">copay</a> / prescription mail order   | Not covered   |   |
|   | <a href="#">Specialty drugs</a>                  | \$77 <a href="#">copay</a> / prescription retail; \$192 <a href="#">copay</a> / 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 |   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)   | \$115 <a href="#">copay</a> /visit, then 20% <a href="#">coinsurance</a>  | \$115 <a href="#">copay</a> /visit, then 40% <a href="#">coinsurance</a>                      | Certain services must be <a href="#">preauthorized</a> by Medi-Call or \$515 penalty per occurrence.  |
|   | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   | Services must be <a href="#">preauthorized</a> by Medi-Call.  |
| <b>If you need immediate medical attention</b>  | <a href="#">Emergency room care</a>              | \$193 <a href="#">copay</a> /visit, then 20% <a href="#">coinsurance</a>  | \$193 <a href="#">copay</a> /visit, then 40% <a href="#">coinsurance</a>                      | Services must be <a href="#">preauthorized</a> by Medi-Call within 48 hours of admission.   |
|   | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   | Certain services must be <a href="#">preauthorized</a> by Medi-Call.  |
|   | <a href="#">Urgent care</a>                      | \$115 <a href="#">copay</a> /visit, then 20% <a href="#">coinsurance</a>  | \$115 <a href="#">copay</a> /visit, then 40% <a href="#">coinsurance</a>                      | None  |
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   | Certain services must be <a href="#">preauthorized</a> by Medi-Call or \$515 penalty per occurrence.  |
|   | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   | Services must be <a href="#">preauthorized</a> by Medi-Call or \$515 penalty/occurrence. Benefits are limited to one consultation per consulting physician for each inpatient hospital stay.  |

|  |   |  |  |   |
|--|---|--|--|---|
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$15 <a href="#">copay</a> /office visit, then 20% <a href="#">coinsurance</a> | \$15 <a href="#">copay</a> /office visit, then 40% <a href="#">coinsurance</a> | Applied Behavior Analysis Therapy and Psychological/Neuropsychological Testing must be <a href="#">preauthorized</a> by Companion Benefit Alternatives.   |
|  | Inpatient services                        | \$15 <a href="#">copay</a> /office visit, then 20% <a href="#">coinsurance</a> | \$15 <a href="#">copay</a> /office visit, then 40% <a href="#">coinsurance</a> | Services must be <a href="#">preauthorized</a> by Companion Benefit Alternatives.   |
| <b>If you are pregnant</b>   | Office visits                             | \$15 <a href="#">copay</a> /office visit, then 20% <a href="#">coinsurance</a> | \$15 <a href="#">copay</a> /office visit, then 40% <a href="#">coinsurance</a> | Services must be <a href="#">preauthorized</a> by Medi-Call. Covered children do not have maternity benefits.   |
|  | Childbirth/delivery professional services | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>  |   |
|  | Childbirth/delivery facility services     | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>  |   |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>  | Services must be <a href="#">preauthorized</a> by Medi-Call. Benefits are limited to 100 visits per year.   |
|  | <a href="#">Rehabilitation services</a>   | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>  | Services must be <a href="#">preauthorized</a> 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-entry programs, long-term rehabilitation, services by a massage therapist or work-hardening programs. |
|  | <a href="#">Habilitation services</a>     | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>  | Habilitative services related to speech therapy are covered through age 6.  |
|  | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>  | Services must be <a href="#">preauthorized</a> by Medi-Call. Benefits limited to 60 days. Physician visits limited to one per day.  |
|  | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>  | Purchase or rental of equipment must be <a href="#">preauthorized</a> by Medi-Call.   |
|  | <a href="#">Hospice services</a>          | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>  | Services must be <a href="#">preauthorized</a> 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.   |
| <b>If your child needs dental or eye care</b>                                    | 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.   |

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

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

### 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](http://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](http://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, kwijigo holne' 888.260.9430.

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

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[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [peba.sc.gov](http://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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$9,730</b> |
|---------------------------|----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$500          |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$2,400        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,970</b> |

**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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$4,280</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$500          |
| <a href="#">Copayments</a>        | \$400          |
| <a href="#">Coinsurance</a>       | \$400          |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,320</b> |

**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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,790</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$500          |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$500          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,010</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.