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 www.peba.sc.gov or call 1-888-260-9430. 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 1-888-260-9430 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,600 individual / $7,200 family If you participate in your employer's HSA, it will pay for qualified medical expenses up to the balance available.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	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 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 1.888.260.9430 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 the specialist you choose without permission from this 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	20% coinsurance	40% coinsurance	In-network Patient-Centered Medical Home visits subject to 10% coinsurance
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge for routine Pap test lab fee or mammograms; 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 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 age 19 and up and for children through age 18. Subscribers age 19 and older may receive an annual physical only from a network provider.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	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.peba.sc.gov.	Generic drugs	Subscriber pays the State Health Plan's allowed amount until the annual deductible is met. Afterward, the subscriber pays 20%. When coinsurance maximum is reached, the Plan will reimburse 100% of the allowed amount.	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		Not covered	
	Non-preferred brand drugs		Not covered	
	Specialty drugs		Not covered	

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

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Services must be preauthorized by Medi-Call
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Services must be preauthorized by Medi-Call.
If you need immediate medical attention	Emergency room care	20% coinsurance	40% coinsurance	Services must be preauthorized by Medi-Call within 48 hours of admission
	Emergency medical transportation	20% coinsurance	40% coinsurance and balance bill	Certain services must be preauthorized by Medi-Call
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Services must be preauthorized by Medi-Call.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Services must be preauthorized by Medi-Call. 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	20% coinsurance	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	20% coinsurance	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	20% coinsurance	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, pulmonary rehabilitation (except in conjunction with a lung transplant), cognitive retraining, community re-entry programs, long-term rehabilitation, services by a message therapist or work-hardening programs.

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

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)	
	Habilitation services	Not covered	Not covered	Not covered
	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 $7,500 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	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No covered	Not covered	None

*For more information about limitations and exceptions, see the plan or policy document at www.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 programs

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

- Chiropractic care
- Infertility treatment
- Non-emergency 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 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. 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: 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.medco.com.

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 the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-803-734-0119.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-803-734-0119.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-803-734-0119.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-803-734-0119.

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 www.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 pre-natal care and a hospital delivery)

The plan's overall deductible	$3,600
Specialist copayment	$0
Hospital (facility) coinsurance	20%
Other coinsurance	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	$6,671

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,520
Copayments	$0
Coinsurance	$2,480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$6,060

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

The plan's overall deductible	$3,600
Specialist copayment	$0
Hospital (facility) coinsurance	20%
Other coinsurance	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	$2,297

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,600
Copayments	$0
Coinsurance	$1,437
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$5,092

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

The plan's overall deductible	$3,600
Specialist copayment	$0
Hospital (facility) coinsurance	20%
Other coinsurance	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	$0

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,540
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,925

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