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 800.868.2520. 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?	Tier A $385 individual / $770 family; Tiers B & C $515 individual / $1,030 family. Doesn't apply to Tier A preventive care or Tiers A & B prescriptions. Copayments do not count toward the deductible.	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?	Tiers A & B $8,150 individual / $16,300 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, balance billing charges and health care this plan doesn't cover. Certain specialty pharmacy drugs are considered nonessential health benefits and are not included in the out–of–pocket limit.	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 the specialist you choose without a referral 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
		MUSC Health Plan Network (Tier A)	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/office or video visit	$15 copay/office or video visit and 20% coinsurance	$15 copay/visit, then 40% coinsurance	None
	Specialist visit	$45 copay	$15 copay/visit and 20% coinsurance	$15 copay/visit, then 40% coinsurance	
	Preventive care/screening/ immunization	No charge for services on Preventive A & B lists	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.	No charge for routine Pap test (subject to balance bill). No other preventive services covered out of network.	For Tiers B/C: 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 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)	$85 copay/X-ray visit at outpatient facility; $20 copay/lab visit at outpatient facility; if done in-office, physician copay only	$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)	$85 copay/ outpatient facility visit; $85 copay/office visit	$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 Evolent or not covered.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at peba.sc.gov	Generic drugs	$10 copay/ prescription retail; $25 copay/90-day supply prescription	$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 might require preauthorization. You pay the difference in price of drug if you request a brand name drug instead of its generic equivalent. Covers certain specialty medications for a $0 copay for members enrolled in SaveOnSP. For members not enrolled in SaveOnSP, the member pays 30% coinsurance. See list of eligible drugs at www.saveonsp.com/pebasc. See "Important Questions" regarding the plan's out-of-pocket limit. There is a 30-day limit per fill on specialty medications and GLP1s.
	Preferred brand drugs	$34 copay/ prescription retail; $90 copay/90-day supply prescription	$46 copay/ prescription retail; $115 copay/ prescription mail order	Not covered	
	Non-preferred brand drugs	$57 copay/ prescription retail; $157 copay/90-day supply prescription	$77 copay/ prescription retail; $192 copay/ prescription mail order	Not covered	
	Specialty drugs	$57 copay/ prescription retail; $157 copay/90-day supply prescription; coinsurance under medical benefit for physician-administered specialty drugs dependent upon place of service	$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	

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

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$290 copay/major surgery; $75 copay/minor surgery	$115 copay/visit, then 20% coinsurance	$115 copay/visit, then 40% coinsurance	Certain services must be preauthorized by Medi-Call.
	Physician/surgeon fees	$25 copay/PCP; $45 copay/specialist	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$193 copay/visit	$193 copay/visit, then 20% coinsurance	$193 copay/visit, then 40% coinsurance	$193 copay waived with hospital admission
	Emergency medical transportation	None; pays under Tier B	20% coinsurance	40% coinsurance	None
	Urgent care	$85 copay/visit	$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)	No charge	20% coinsurance	40% coinsurance	Certain services must be preauthorized by Medi-Call.
	Physician/surgeon fees	20% coinsurance	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	$25 copay for professional services; $25 copay for outpatient facility	$15 copay/visit, then 20% coinsurance	$15 copay/visit, then 40% coinsurance	Applied Behavior Analysis Therapy and Psychological/Neuropsychological Testing must be preauthorized by Companion Benefit Alternatives.
	Inpatient services	No facility charge; 20% coinsurance for professional services	20% coinsurance	40% coinsurance	Services must be preauthorized by Companion Benefit Alternatives.
If you are pregnant	Office visits	$25 copay/PCP visit; $45 copay/specialist visit	$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	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	No facility charge	20% coinsurance	40% coinsurance	

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

If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	40% coinsurance	Services must be preauthorized by Medi-Call. Benefits are limited to 100 visits per year.
	Rehabilitation services	20% coinsurance	$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	20% coinsurance	$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	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	20% coinsurance	40% coinsurance	Purchase or rental of equipment must be preauthorized by Medi-Call.
	Hospice services	None; pays under Tiers B & C	20% coinsurance	40% coinsurance	Services must be preauthorized by Medi-Call. Benefits are limited to 80 days for a patient certified by their physician as having a terminal illness and a life expectancy of six months or fewer.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Coverage provided under separate vision plan.
	Children's glasses	Not covered	Not covered	Not covered	Coverage provided under separate vision plan.
	Children's dental checkup	Not covered	Not 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	• 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, call PEBA at 888.260.9430. Other coverage options might 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 grievance for any reason to your plan. For more information about your rights, this notice or assistance, call 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 might 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 might 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	$385
Specialist *[cost sharing]*	$45
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	**$11,055**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$385
Copayments	$200
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,645**

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

The plan's overall deductible	$385
Specialist *[cost sharing]*	$45
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	**$4,395**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$385
Copayments	$700
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,205**

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

The plan's overall deductible	$385
Specialist *[cost sharing]*	$45
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	**$1,715**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$385
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,085**

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