

Plan Design For: South Carolina Bankers Employee Benefit Trust  
Plan Name: Gold  
Effective Date: January 1, 2020

*The following Benefit Summary is only a brief, non-legal outline of the benefits offered.*

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
MEDICAL AND SURGICAL BENEFITS		
Deductible (Embedded*)	\$2,500 Individual / \$5,000 Family	\$5,000 Individual / \$10,000 Family
Coinsurance (Shown as percentages below)	\$3,500 Individual / \$7,000 Family	\$5,000 Individual / \$10,000 Family
Standard Out-of-Pocket Includes Deductible and Coinsurance		\$10,000 Individual / \$20,000 Family
Standard Out-of-Pocket: Allowable charges for Coinsurance are paid at 100% after the Standard Out-of-Pocket is met.		
In-Network Maximum Out-of-Pocket Includes Deductible, Co-pays and Coinsurance	\$6,000 Individual / \$12,000 Family	
Physician Services in the Office Excluding Obstetrical Delivery, Dialysis Treatment, Chemotherapy, Radiation and Second Surgical Opinion  Includes Office Surgery, Lab and X-ray.	\$25 Primary Care Co-pay, then 100% \$50 Specialist Co-pay, then 100%  Primary Care = General, Family Doctor, Pediatrician, Internist, OB/GYN	Deductible, 50%
Blue CareOnDemand <sup>SM</sup>	\$25 Co-pay, then 100%	Not Covered
Other Physician Services Inpatient/Outpatient hospital, allergy injections, anesthesia services, radiology, chemotherapy, dialysis, pathology, obstetrical delivery, initial new born pediatric exam and all other outpatient/office services	Deductible, 80%	Deductible, 50%
Wellness Benefits – Based on the Health Care Reform Guidelines refer to www.healthcare.gov	100%	Not Covered
Sustained Health Services (\$200 annual maximum)	\$25 Co-pay, then 100%	Not Covered
Annual Physicals and Sustained Health Services are only covered at a Primary Care Provider.		
Inpatient Facility Charges	\$100 Co-Pay, 80%	\$200 Co-Pay, 50%
Skilled Nursing Facility Charges (60 days per year)	\$100 Co-Pay, 80%	\$200 Co-Pay, 50%
Outpatient Facility Charges	Deductible, 80%	Deductible, 50%
Other Services Physical/Occupational Therapy (30 combined visits) Home Healthcare Hospice	Deductible, 80%	Deductible, 50%
Chiropractic Benefits (\$500 annual maximum)	Deductible, 50%	Deductible, 50%
Independent Labs	Deductible, 80%	Deductible, 50%
Ambulance	Deductible, 80%	In-Network Deductible, 80%
Urgent Care	\$50 Co-pay, then 100%	Deductible, 50%
Emergency Room Facility Charges **	\$200 Co-Pay, Deductible, 80%	Deductible, 50%
Emergency Room Professional Charges **	Deductible, 80%	Deductible, 50%
**Out-of-Network Emergency Facility and Professional charges are subject to In-Network Coinsurance and/or Co-pay and Out-of-Network Benefit Year Deductible and Out-of-Pocket.		
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS		
Inpatient Facility Charges	\$100 Co-Pay, 80%	\$200 Co-Pay, 50%
Inpatient Professional Charges	Deductible, 80%	Deductible, 50%
Outpatient Facility Charges	Deductible, 80%	Deductible, 50%
Outpatient Professional Charges	Deductible, 80%	Deductible, 50%
Emergency Room Facility Charges	\$200 Co-Pay, Deductible, 80%	\$200 Co-Pay, Deductible, 70%
Emergency Room Professional Charges	Deductible, 80%	Deductible, 70%
Physician Services in the Office	\$30 Copay, then 100%	Deductible, 50%
PHARMACY BENEFITS		
Prescriptions Mandatory Generic (Includes diabetic supplies and oral contraceptives) Retail (31 day supply)*** Mail Order (90 day supply)	\$15 (Generic) / \$40 (Preferred) / \$70 (Non-Preferred) \$25 (Generic) / \$90 (Preferred) / \$175 (Non-Preferred)	50% after Co-pay Not Covered
***Member may purchase a 90 day Supply of a Generic Prescription, however 3 Retail Generic co-pays will apply at the time of purchase.		
Specialty Drug – BrivoRx Specialty Pharmacy Only 1-877-259-9428 for inquiries regarding this benefit	\$125 Co-pay per 31 day supply	
BENEFIT MAXIMUMS		
Annual / Lifetime Maximum	Unlimited	

\*Embedded Deductible: An individual deductible "embedded" within the family deductible. Before the insurance benefits begin the individual must meet the embedded individual deductible amount, which is equal to the single coverage deductible.