2019 Open Enrollment

It's time to make choices for 2020. Open Enrollment allows you to make changes between October 1st thru October 31st. All premium and plan changes are effective January 1, 2020. You do not need to do anything if you are satisfied with your current insurance coverage; however, enrollment or re-enrollment in the MoneyPlus medical spending or dependent care accounts is required every year.

To review or make changes to your insurance benefits, register for the PEBA website "My Benefits" (https://mybenefits.sc.gov). To register, employees will need the Benefits Identification Number (BIN) from their health insurance card or may obtain their BIN from the "My Benefits" website. The website is now available to make changes.

What's new for 2020?

- Employee health, life insurance, and long term disability premiums will remain the same. Vision premiums and dental plus employee tier insurance premiums will be decreasing.

What you can do during 2019 Open Enrollment

- **Dental**
  - You can add or drop basic or dental plus for you and your dependents. Note, changes to existing dental coverage for **both basic dental and dental plus** can only be made in odd numbered open enrollment years. Your next opportunity to add or drop basic dental or Dental Plus coverage for yourself and or your dependents after this Open Enrollment will be October 2021.
- **Health**
  - Enroll in or drop for yourself and/or eligible dependents*.
  - State Savings plan participants can switch to the MUSC Health Plan. Note, new enrollment in the State Savings plan is not allowed.
- **Medical Spending or Dependent Care Accounts (required every year)**
  - Enroll or re-enroll. Participants may carry over up to $500 of unused 2019 Medical Spending Account funds into 2020.
- **Optional employee and spouse life insurance**
  - Enroll in or increase only with medical evidence of insurability. Contact the Benefits office for forms.
  - Drop or decrease life insurance coverage.
- **Optional dependent child life insurance**
  - Enroll in or drop dependent life-child coverage*. Note, you can add or drop this benefit anytime throughout the year.
- **Supplemental Long Term Disability**
  - With medical evidence of insurability, active employees may apply to enroll or change the waiting period from 180 to 90 days in SLTD coverage throughout the year. Contact the Benefits office for forms.
  - Current participants may drop coverage or increase waiting period.
- **Tricare Supplement**
  - Enroll in or drop-for members of the military community.
- **Vision**
  - Enroll in or drop for yourself and/or eligible dependents*.

MUSC
Medical University of South Carolina

*Documentation is required to add dependents to coverage.
Please email benefits@musc.edu for next steps or visit our website https://web.musc.edu/human-resources/university-hr/benefits

Changing What's Possible

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Setting Up a New MyBenefits Account

MyBenefits is the fastest, most convenient way for subscribers covered by PEBA-administered insurance programs to manage their benefits. Enroll in MyBenefits today and start managing your insurance information.

Step 1

Go to PEBA's website, www.peba.sc.gov, and select the MyBenefits button on the right side of the page.

Step 2

If you don't know your Benefits Identification Number (BIN), select Get My BIN and follow the instructions to retrieve it.

Step 3

To set up an account, select the Register button. Follow the five-step process to complete your registration.

Log in to MyBenefits 24/7 by entering your BIN, the last four digits of your Social Security number and your password.

- Access your insurance benefits information.
- Update your contact information.
- Review and change your beneficiaries.
- Make changes to your coverage during the annual open enrollment period in October and some special eligibility situations.

SCPEBA 072019 | Expires 12312020
Data classification: public information

2020 Comparison of Health Plan Benefits for MUSC Employees

Version Date: 01/24/19

	MUSC Health Plan		
Monthly Premiums			
Employee	$97.68		
Employee/Spouse	$253.36		
Employee/Children	$143.86		
Full Family	$306.56		
Availability	MUSC Network, approved pedatricians, National Allergy & Asthma, and Doctors Care	Outside MUSC Network - Standard State Health Plan approvedproviders	Not in MUSC Network and not a Standard State Health Plan approved provider
	Tier A	Tier B	Tier C
Annual Deductible			
Single	$385	$490	
Family	$770	$980	
	Plan pays 80%, you pay 20%	Standard State Health Plan	Out-of-Network
Coinsurance	Deductible and coinsurance not applicable for physicians' visits, certain outpatient services, and hospital facility charges associated with an inpatient hospital stay. PT, OT, & Speech Therapy are subject to deductible and coinsurance	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%
Coinsurance Maximum			
Single	$2,200	$2,800	$5,600
Family	$4,400	$5,600	$11,200
	(excludes deductible)	(excludes deductible)	(excludes deductible)
	Addt'l copays may apply for each professional service provided. See MUSC Health Plan Summary of Benefits.		
Physician Office Visits	Annual deductible & coinsurance do not apply $25 - Rapid Access Clinic & Primary Care Physician copay $45 - Specialist Physician copay $0 - copay for ACA approved preventive visits & annual well-woman exam	$490 annual deductible first. $14 copay, then coinsurance: Copay waived if service performed at a Patient Centered Medical Home (PCMH) In-Network: Plan pays 80%, You pay 20% (If PCMH, you pay 10%) Out-of-Network: Plan pays 60%, You pay 40% Maximum Annual Chiropractic payments - $2,000	
Outpatient	$265 copay for hospital surgical out-patient, $75 for radiology & $20 for Pathology.	$105 copay, deductible & coinsurance.	
Hospitalization	Deductible and 20% coinsurance for physician fees, but no copay for inpatient hospital services.	Hospitalization subject to deductible & coinsurance.	
Urgent/ Emergency Care	Urgent: $75 copay at Doctors Care; ER: $175 copay, plus deductible & 20% coinsurance	Urgent: Deductible & coinsurance; ER: $175 copay, deductible & coinsurance	
Prescription Drugs	MUSC Retail Pharmacies Tier I (generic-lowest cost alternative): $6 Tier 2 (brand-higher cost alternative): $30 Tier 3 (brand-highest cost alternative): $50 90 day supply Tier 1 (Generic): $15 Tier 2 (Preferred brand): $80 Tier 3 (Non-preferred brand): $140 Copay maximum: $2,500	Participating pharmacies only (up to a 31 day supply) Tier 1 (generic-lowest cost alternative): $9 Tier 2 (brand-higher cost alternative): $42 Tier 3 (brand-highest cost alternative): $70 Mail order (up to a 90 day supply) Tier 1 (Generic): $22 Tier 2 (Preferred brand): $105 Tier 3 (Non-preferred brand): $175 Copay maximum: $3,000	

Dental		
	Basic	Plus
Employee	$0.00	$25.96
Employee/Spouse	$7.64	$60.12
Employee/Children	$13.72	$74.26
Full Family	$21.34	$99.98

Vision	
Employee	$5.80
Employee/Spouse	$11.60
Employee/Children	$12.46
Full Family	$18.26

Please refer to the website (https://www.musc.edu/medcenter/MUSChealthplan/index.html) to ensure that you are viewing the latest version of this chart.

[1]Refer to your 2020 Insurance Summary for information on how this plan coordinates with Medicare.

[2]Subscribers who use tobacco or cover dependents who use tobacco will pay a tobacco surcharge - $40 monthly surcharge for subscriber-only coverage, $60 monthly for other levels of coverage.

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2020 monthly insurance premiums for active employees[1, 2]

	Employee	Employee/spouse	Employee/children	Full family
MUSC Health Plan	$97.68	$253.36	$143.86	$306.56
Savings Plan*	$9.70	$77.40	$20.48	$113.00
TRICARE Supplement	$62.50	$121.50	$121.50	$162.50
Dental	$0.00	$7.64	$13.72	$21.34
Dental Plus	$25.96	$60.12	$74.26	$99.98
Vision	$5.80	$11.60	$12.46	$18.26
Tobacco-use premium	$40.00	$60.00	$60.00	$60.00

Employer contributions[1]

	Employee	Employee/spouse	Employee/children	Full family
Health	$402.70	$797.68	$618.06	$998.72
Dental	$13.48	$13.48	$13.48	$13.48
Life	$0.32	$0.32	$0.32	$0.32
Long term disability	$3.22	$3.22	$3.22	$3.22

Life insurance

Optional Life and AD&D and Dependent Life-Spouse and AD&D

Coverage will reduce to 65 percent at age 70, 42 percent at age 75 and 31.7 percent at age 80. Rates shown per $10,000 of coverage.

Age	Monthly rate
Under 35	$0.58
35-39	$0.78
40-44	$0.86
45-49	$1.22
50-54	$1.94
55-59	$3.36
60-64	$6.00
65-69	$13.50
70-74	$24.22
75-79	$37.50
80 and over	$62.04

Dependent Life - Child

$1.26 per month for $15,000 of coverage; one premium provides coverage for all eligible children.

SLTD Plan monthly premium rates

Age on preceding January 1	90-day waiting period	180-day waiting period
Under 31	.00065	.00052
31-40	.00090	.00070
41-50	.00179	.00136
51-60	.00361	.00277
61-65	.00434	.00333
66 and older	.00530	.00407

To estimate your SLTD monthly premium:

1. Divide gross annual salary by 12 to determine monthly salary.
2. Multiply monthly salary by rate factor from table.
3. Drop digits to right of two decimal places; do not round.
4. If number is even, this is the monthly premium.
5. If number is odd, add $0.01 to determine monthly premium.

* The Savings Health Plan is only available to grandfathered employees. Grandfathered employees are those enrolled prior to 2014.

1 Premiums for local subdivisions may vary. To verify your rates, contact your benefits office.

2 State Health Plan subscribers who use tobacco or cover dependents who use tobacco will pay a $40 per month premium for subscriber-only coverage. The premium is $60 for other levels of coverage. The tobacco-use premium does not apply to TRICARE Supplement subscribers.

Chooseyour dentalplan.

You have twooptions for dental coverage. Dental Plus pays moreand has higher premiumsand lowerout-of-pocket costs.BasicDentalpayslessandhaslowerpremiumsandhigherout-of-pocket costs. Changes to existing dental coverage can be made only during open enrollment in odd- numberedyears.Learnmoreabouttheplansat **www.peba.sc.gov/dental.html**.

Dental Plus

Dental Plushashigher allowedamounts, which arethe maximum amounts allowed by theplan for acovered service. Network providers cannot charge you for the difference in their cost and the allowed amount.

Basic Dental

Basic Dentalhas lower allowed amounts, whicharethe maximum amounts allowed by the plan for a covered service. There is nonetwork for Basic Dental; therefore, providers can chargeyou for the difference in their cost andthe allowedamount.

	Dental Plus	Basic Dental
Diagnostic and preventive *Exams, cleanings, X-rays*	You do not pay a deductible. The Plan will pay 100% of a **higherallowedamount**. Innetwork, a provider **cannot charge you for the difference** initscostandthe allowedamount.	You do not pay a deductible. The Plan will pay 100% of a **lowerallowed amount**. A provider **can charge you for the difference** in its cost and the allowedamount.
Basic *Fillings, oral surgery, root canals*	You pay up to a **$25** deductible per person.[1]The Plan willpay 80% ofa **higherallowedamount**. In network, a provider **cannot charge you for the difference**inits costandtheallowedamount.	You pay up to a **$25** deductible per person.[1]The Plan will pay 80% of a **lower allowed amount**. A provider **can charge you for the difference** in its cost and the allowed amount.
Prosthodontics *Crowns, bridges, dentures, implants*	You pay up to a **$25** deductible per person.[1]The Plan willpay 50% ofa **higherallowedamount**. In network, a provider **cannot charge you for the difference**inits costandtheallowedamount.	You pay up to a **$25** deductible per person.[1]The Plan will pay 50% of a **lower allowed amount**. A provider **can charge you for the difference** in its cost and the allowed amount.
Orthodontics[2] *Limited to covered children ages 18 and younger.*	You do not pay a deductible. There is a $1,000 lifetime benefit for each covered child.	You do not pay a deductible. There is a $1,000 lifetime benefit for each covered child.
Maximum payment	$2,000perpersoneachyearfordiagnosticand preventive, basic and prosthodontics services.	$1,000perpersoneachyearfordiagnosticand preventive, basic and prosthodontics services.

[1] If you have diagnostic and preventive, basic or prosthodontics services, you pay only one deductible. Deductible is limited to three per family per year.
[2] There is a $1,000 maximum lifetime benefit for each covered child, regardless of plan or plan year.

2020 Monthly premiums

If you work for an optional employer, verify your rates with your benefits office.

	Employee	Employee/spouse	Employee/children	Full family
Dental Plus	$25.96	$60.12	$74.26	$99.98
Basic Dental	$0.00	$7.64	$13.72	$21.34

Scenario 1: Routine checkup

Includes exam, four bitewing X-rays and adult cleaning

	Dental Plus		Basic Dental
	In network	Out of network	
Dentist's initial charge	$191.00	$191.00	$191.00
Allowed amount[3]	$135.00	$171.00	$67.60
Amount paid by the Plan (100%)	$135.00	$171.00	$67.60
Your coinsurance (0%)	$0.00	$0.00	$0.00
Difference between allowed amount and charge	$56.00 *Dentist writes off this amount*	$20.00	$123.40
You pay	$0.00	$20.00 *Difference in allowed amount and charge*	$123.40 *Difference in allowed amount and charge*

Scenario 2: Two surface amalgam fillings

	Dental Plus		Basic Dental
	In network	Out of network	
Dentist's initial charge	$190.00	$190.00	$190.00
Allowed amount[4]	$145.00	$177.00	$44.80
Amount paid by the Plan (80%)	$116.00	$141.60	$35.84
Your coinsurance (20%)	$29.00	$35.40	$8.96
Difference between allowed amount and charge	$45.00 *Dentist writes off this amount*	$13.00	$145.20
You pay	$29.00 *20% coinsurance*	$48.40 *20% coinsurance plus difference*	$154.16 *20% coinsurance plus difference*

[3] *Allowed amounts may vary by network dentist and/or the physical location of the dentist.*
[4] *Example assumes that the $25 annual deductible has been met.*

What you can do during open enrollment:

- Change from one dental plan to another:
  - Dental Plus; or
  - Basic Dental.
- Enroll yourself or any eligible dependents in dental coverage.
- Drop dental coverage for yourself or any dependents.

How much will you spend on dental care?

Include this amount on the worksheet on Page 11 to determine how much you should contribute to your MoneyPlus account.

Amount $ _____

Administered by:

EyeMed

State Vision Plan

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Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only

Take a sneak peek before enrolling

- For a complete list of in-network providers near you, visit www.peba.sc.gov. You can also call 877.735.9314.
- For LASIK providers, call 877.5LASER6.

SUMMARY OF BENEFITS

Vision care services	In-network member cost	Out-of-network reimbursement
Exam with dilation as necessary	$10 copay	Up to $35
Retinal imaging	Up to $39	N/A
Frames	$0 copay, $150 allowance, 20% off balance over $150	Up to $75
Standard plastic lenses		
Single vision	$10 copay	Up to $25
Bifocal	$10 copay	Up to $40
Trifocal	$10 copay	Up to $55
Lenticular	$10 copay	Up to $55
Standard progressive lens	$35 copay	Up to $55
Premium progressive lens[Δ]	$55 - $80 copay	
Tier 1	$55	Up to $55
Tier 2	$65	Up to $55
Tier 3	$80	Up to $55
Tier 4	$35 copay, 80% of charge less $120 allowance	Up to $55
Lens options		
UV treatment	$0	Up to $5
Tint (solid and gradient)	$0	Up to $5
Standard plastic scratch coating	$0	Up to $5
Standard polycarbonate–adults	$30 copay	Up to $5
Standard polycarbonate–kids under 19	$0	Up to $5
Standard anti-reflective coating	$45	N/A
Premium anti-reflective coating[Δ]	$57-$68	N/A
Tier 1	$57	N/A
Tier 2	$68	N/A
Tier 3	80% of charge	N/A
Photochromic/Transitions plastic	$60	Up to $5
Polarized	20% off retail	N/A
Other add-ons and services	20% off retail	N/A
Contact lens fit andfFollowuUp (Contact lens fit and follow up visits are available once a comprehensive eye exam has been completed)		
Standard contact lens fit & follow-up	$0 copay, paid-in-full and two follow-up visits	Up to $40
Premium contact lens fit & follow-up	$0 copay, 10% off retail price, then apply $40 allowance	Up to $40
Contact lenses (Contact lens allowance includes materials only.)		
Conventional	$0 copay, $130 Allowance, 15% off balance over $130	Up to $104
Disposable	$0 copay, $130 Allowance; plus balance over $130	Up to $104
Medically necessary	$0 copay, paid-in-full	Up to $200
Laser vision correction		
LASIK or PRK from U.S. laser network	15% off the retail price or 5% off the promotional price	N/A
Hearing Care		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and a low price guarantee on discounted hearing aids	N/A
Frequency		
Examination	Once every year	
Lenses or contact lenses	Once every year	
Frame	Once every year	

Benefits are not provided from services or materials arising from: Orthopic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses, medical and/or surgical treatment of the eye, eyes or supporting structures; Any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (non-prescription) lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; Services rendered after the date an insured person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the insured Person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered – fund as a Bifocal lens. Standard Progressive lens covered – fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use with the same benefits year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered. This is a snapshot of your benefits. [Δ]Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.

Choose your MoneyPlus elections.

Are you leaving money on the table? MoneyPlus is a tax-favored accounts program that allows you to save money on eligible medical and dependent care costs. You fund the accounts with money deducted pretax from your paycheck. Learn more about your MoneyPlus options at **www.peba.sc.gov/moneyplus.html**.[1]

Standard Plan members

Medical Spending Account

Use your MSA to pay for eligible medical expenses, including copayments and coinsurance. As you have eligible expenses, you can use a debit card for your account or submit claims for reimbursement. You can carry over into 2021 up to $500 in unused funds from your account. You must re-enroll each year.

Savings Plan members

Health Savings Account

Your Savings Plan is designed to go hand in hand with a Health Savings Account (HSA). With an HSA, you can save up to $875 a year in taxes.[2]

- Pay for out-of-pocket medical expenses, such as deductibles and prescriptions.
- Carry over all funds from one year to the next.
- You own the account and keep it if you leave your job or retire.
- While there is an annual contribution limit, there's no limit to how much you can save in your account.
- You can invest funds to earn investment income tax- free.

Limited-use Medical Spending Account

If you have a Health Savings Account, you can also use a Limited-use Medical Spending Account to pay for those expenses the Savings Plan does not cover, like dental and vision care.

Account type	Plan	Funds available	Medical expenses	Dental, vision expenses	Balance carries from year-to-year	Invest funds	Re-enroll each year
MSA	Standard	January 1	✓	✓	Up to $500		✓
HSA	Savings	As deposited	✓	✓	✓	✓	
Limited-use MSA	Savings	January 1		✓	Up to $500		✓

[1] Contributions made before taxes lower your taxable earned income. The lower your earned income, the higher the earned income tax credit. See IRS Publication 596 or talk to a tax professional for more information.

[2] Based on a hypothetical individual with an income of $40,000 per year, taxed at 25 percent, who contributes $3,500 to his HSA in 2019.

All members

Pretax Group Insurance Premium feature

This feature allows you to pay insurance premiums before taxes for health, vision, dental and upto$50,000 of Optional Life coverage. You do not need to re-enroll each year.

Dependent Care Spending Account

You can use a Dependent Care Spending Account (DCSA) to pay for daycar ecosts for children and adults. It cannot be used to pay for dependent medical care. You submit claims for reimbursement as you have eligible expenses. The funds can be used only for expenses incurred January 1, 2020, through March 15, 2021. You forfeit funds left in your account after the reimbursement deadline. You must re-enroll eachyear.

Monthly fees	
edical Spending Account	$2.32
Health Savings Account	$1.00
Limited-use edical Spending Account	$2.32
Dependent Care Spending Account	$2.32
Central Bank (HSA)	
Maintenance fee (balances less than $2,500)	$1.25
Paper statements	$3.00

2020 Contribution limits

Account	Limit
Medical Spending Account[2]	$2,700
Health Savings Account	$3,550 (self-only coverage) $7,100 (family coverage) $1,000 (catch-up for age 55 or older)
Limited-use Medical Spending Account[2]	$2,700
Dependent Care Spending Account[2,3]	$2,500 (married, filing separately) $5,000 (single, head of household) $5,000 (married, filing jointly)

[2] These are 2019 limits; contribution limits for 2020 will be released by the IRS at a later date.
[3] Contribution limit for highly compensated employees is $1,700.

2020 Reimbursement deadlines

Account	Grace period	Deadline
Medical Spending Account	None	March 31, 2021
Limited-use Medical Spending Account	None	March 31, 2021
Dependent Care Spending Account	March 15, 2021	March 31, 2021

What you can do during open enrollment:

- Enroll in or drop the Pretax roup Insurance Premium feature.
- Enroll in, re-enroll in or drop flexible spending accounts:
  - edical Spending Account.
  - Limited-use edical Spending Account.
  - Dependent Care Spending Account.
- Enroll in or drop a Health Savings Account.

Your benefits on the go

Did you know your phone can be your go-to resource for accessing your insurance benefits information? Mobile apps are available for your health, dental, prescription, vision and flexible spending benefits.

BlueCross BlueShield of South Carolina

Search for My Health Toolkit.

Health and dental benefits

- Learn about your coverage.
- Find a provider.
- Check status of claims.
- Access your identification card.

Express Scripts

Search for Express Scripts.

Prescription benefits

- Check if a drug requires prior authorization and compare drug prices.
- Locate a network pharmacy.
- Refill and renew mail order prescriptions.
- Access your identification card.

EyeMed

Search for EyeMed Members.

Vision benefits

- Learn about your coverage.
- Search for network providers.
- Set eye exam and contact lens change reminders.
- Access your identification card.

ASIFlex

Search for ASIFlex Self Service.

Flexible spending accounts

- Submit and view status of a claim.
- Submit documentation.
- View account details.
- Read secure account messages.

Call ahead to get the green light for your care

Some medical and behavioral health services need preauthorization

Some medical and behavioral health services need preauthorization for the State Health Plan to provide coverage. This means you or your provider need to make a phone call. **Not calling for preauthorization may lead to a $490 penalty.** Preauthorization does not guarantee payment.

Medical services

To preauthorize your medical treatment, call Medi- Call at 800.925.9724. Contact Medi-Call at least two business days before:

- Inpatient care in a hospital, including admission to a hospital to have a baby.
- An outpatient service that results in a hospital admission.
- Outpatient surgery for a septoplasty (surgery on the septum of the nose).
- Outpatient or inpatient surgery for a hysterectomy.
- Sclerotherapy (vein surgery).
- Chemotherapy or radiation therapy.
- Admission to a long-term care facility or nursing facility.
- Ordering durable medical equipment.
- In vitro fertilization or other infertility procedures.
- An organ transplant.
- Inpatient rehabilitation services and related outpatient physical, speech or occupational therapy.

Pregnancy

You should contact Medi-Call within the first three months of a pregnancy.

Emergencies

In a hospital emergency, you should contact Medi- Call within 48 hours of admission.

Behavioral health services

To preauthorize your behavioral services, call Companion Benefit Alternatives at 800.868.1032.

- Inpatient hospital care.
- Intensive outpatient hospital care.
- Partial hospitalization care.
- Outpatient electroconvulsive therapy.
- Repetitive transcranial magnetic therapy.
- Applied behavioral analysis therapy.
- Psychological/neuropsychological testing.

Radiology services

To preauthorize your radiology services, call National Imaging Associates at 866.500.7664.

- CT scan.
- MRI.
- MRA.
- PET scan.

Preventive services

Adult well visits and the MUSC Health Plan

Well visits may be a key part of preventive care. They can reassure you that you are as healthy as you feel, or prompt you to ask questions about your health. Learn more about adult well visits and how they are covered at www.peba.sc.gov/wellvisits. html.

How the benefit works

Evidence-supported services, based on United States Preventive Services Task Force (USPSTF) A and B recommendations, are included as part of an adult well visit under the State Health Plan. After talking with your doctor during a visit, the doctor can decide which services you need and build a personal care plan for you. Adult well visits are subject to copayments, deductibles and coinsurance in covered years.

Who is eligible?

The benefit is available to all non-Medicare primary adults ages 19 and older who are covered by the Standard Plan. Adult members can take advantage of this benefit at an eligible network provider.

Eligible female members may use their well visit at their gynecologist or their primary care physician, but not both, in a covered year. If a woman visits both doctors in the same covered year, only the first routine office visit received will be covered.

Women ages 18-65 can receive a Pap test each calendar year at no member cost through PEBA Perks. In years when you are not eligible for an adult well visit, you can still receive a Pap test at no member cost.

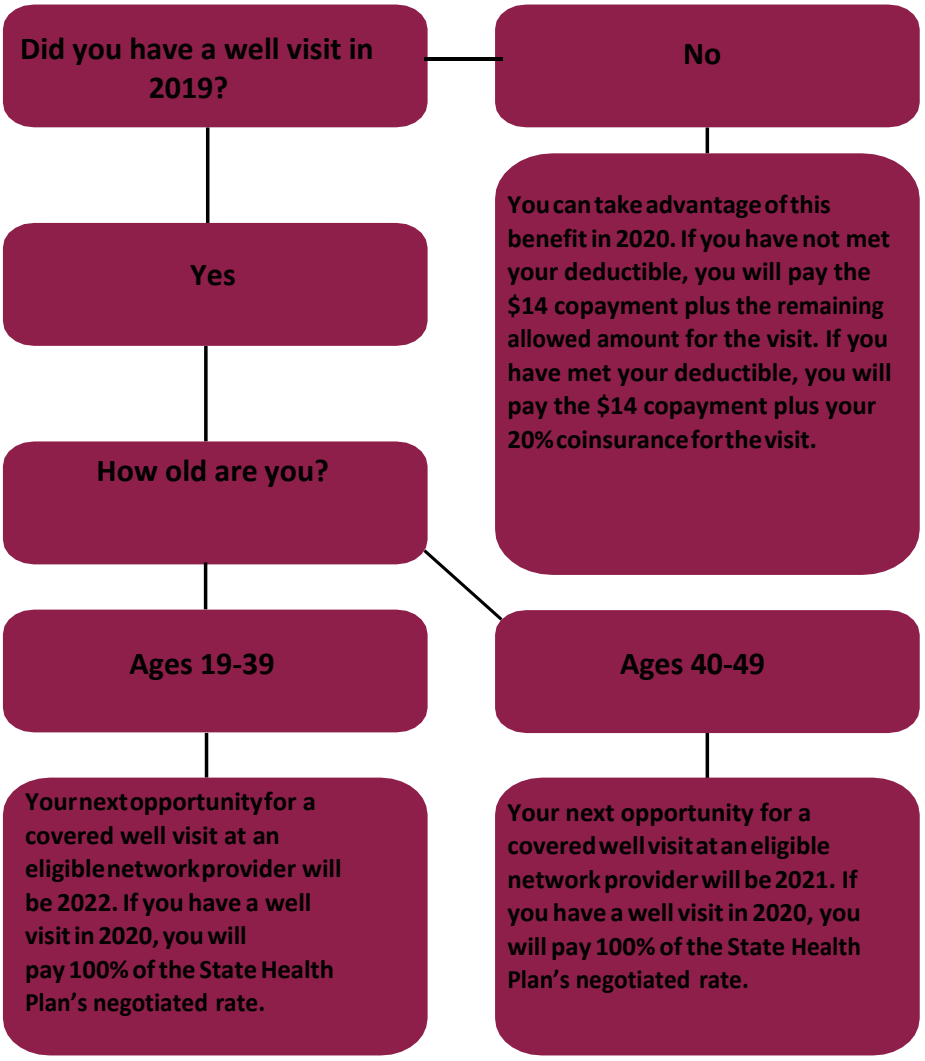
	Once a year	Once every two years	Once every three years
Ages 19-39			X
Ages 40-49		X	
Ages 50 and up	X		

Services not included as part of an adult well visit

Services not included as part of the adult well visit are those without an A or B recommendation by the USPSTF. Find these recommendations at www. USPreventiveServicesTaskForce.org. Other services, including a complete blood count (CBC), EKG, PSA test and basic metabolic panel, if ordered by your physician to treat a specific condition, may still be covered. These services are subject to copayments, deductibles and coinsurance, as well as normal Plan provisions. Follow-up visits and services as a result of your well visit are also subject to normal Plan provisions.

Can you get a well visit in 2020 if you're younger than age 50?

Members age 50 and older may have a well visit every year. Members younger than age 50 can determine when they may have a well visit by following the flow chart on Page 7.



In non-covered years, the amount you pay for a well visit will not apply toward your deductible or coinsurance maximum.

How to get the most out of your benefits. The State Health Plan offers many value-based benefits at no member cost to primary members through PEBA Perks. Learn how to coordinate PEBA Perks benefits with your adult well visit below.

Get your preventive screening. You can receive a biometric screening at no cost, which will minimize cost to you at your adult well visit. The screening includes comprehensive blood work with lipid panels, a health risk appraisal, blood pressure screening and height and weight measurements.

Have your adult well visit after your preventive screening. USPSTF A and B recommendations are included as part of an adult well visit. After talking with your doctor during a visit, the doctor can decide which services you need and build a personal care plan for you.

Share your preventive screening results with your doctor. You will receive a confidential report with your screening results, and we recommend you share it with your doctor to eliminate the need for retesting at a well visit. Sharing your results will minimize the cost of your adult well visit.

Follow your doctor's recommendations and stay engaged with your health. We encourage you to take advantage of the other PEBA Perks available to you. If you're eligible, sign up for No-Pay Copay to receive some generic drugs at no cost to you. To learn more, go to www.PEBAperks. com.

Adult well visits and the Savings Plan

Savings Plan members are eligible for one well visit each year at no member cost. Evidence-supported services, based on the USPSTF A and B recommendations, are included as part of an adult well visit.
After talking with your doctor during a visit, your doctor can decide which services you need and build a personal care plan for you.