



**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, call 1-877-234-5550. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You may view the Glossary at [healthcare.gov/sbc-glossary](http://healthcare.gov/sbc-glossary) or call 1-877-234-5550 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<p>Calendar Year <u>deductibles</u>:</p> <p>Tier 1—\$1,700 Individual/\$3,000 Employee + Dependent(s)</p> <p>Tier 2—\$3,200 Individual/\$6,500 Employee + Dependent(s)</p>	<p>Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
<b>Are there services covered before you meet your deductible?</b>	<p>Yes. Tiers 1 &amp; 2 <u>preventive services</u> and routine vision exams office visits are some of services covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at <a href="http://healthcare.gov/coverage/preventive-care-benefits">healthcare.gov/coverage/preventive-care-benefits</a>.</p>
<b>Are there other deductibles for specific services?</b>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<b>What is the out-of-pocket limit for this plan?</b>	<p>Tier 1—\$4,000 Individual/\$8,000 Employee + Dependent(s)</p> <p>Tier 2—\$6,150 Individual/\$12,300 Employee + Dependent(s)</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> is met.</p>
<b>What is not included in the out-of-pocket limit?</b>	<p><u>Preauthorization</u> penalties, <u>premiums</u>, <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<b>Will you pay less if you use a network provider?</b>	<p>Yes. See <a href="http://southcoasthealthplan.org">southcoasthealthplan.org</a> or call 1-877-234-5550 for a list of <u>network providers</u>.</p>	<p>You pay the least if you use a Tier 1 <u>provider</u>. You may pay more if you use a Tier 2 <u>provider</u>. You pay the most if you use an <u>out-of-network provider</u> (Tier 3) and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance-billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<b>Do you need a referral to see a specialist?</b>	<p>No.</p>	<p>You may see a <u>specialist</u> you choose without a <u>referral</u>.</p>

Note—Health Management Programs: For services related to Oncology care management, Southcoast has a care management program in place that requires a member to consult with a Southcoast specialist prior to beginning treatment. There is a financial penalty of \$500 when a member does not follow this process. Please contact Conifer Health Solutions at (800) 459-2110 for further details.



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
		Southcoast Hospitals & Physician Network [Tier 1]	Preferred Providers [Tier 2]	Excluded Facilities, Steward/Out-Of-Network Providers [Tier 3]	
		(You pay the least)	(You may pay more)	(You pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$40 <u>copay</u> /visit; <u>deductible</u> waived	40% <u>coinsurance</u> *	40% <u>coinsurance</u> after Tier 2 <u>deductible</u> for Steward Physician charges. Related charges not covered.	You may have to pay for services that aren't <u>preventive</u> . Ask <u>provider</u> if services are <u>preventive</u> . Check what <u>plan</u> will pay. * <u>Preauthorization</u> required for oncologist or hematologist.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit; <u>deductible</u> waived			
	<u>Preventive care/Screening/Immunization</u>	No charge; <u>deductible</u> waived	40% <u>coinsurance</u>		
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge; <u>deductible</u> waived	40% <u>coinsurance</u> **	Not covered	*Includes nuclear cardiology services. ** <u>Preauthorization</u> required for Imaging or you pay \$250 more.
	<u>Imaging*</u> (CT/PET scans, MRI, MRA)				
<b>If you need drugs to treat your illness or condition.</b> More information about <b><u>prescription drug coverage</u></b> is available at Southcoasthealth plan.org	Generic drugs (Tier 1)	<b>Southcoast Pharmacies</b> \$10* up to 30 days' supply \$25* up to 90 days' supply	<b>CVS/Caremark</b> \$20 retail network \$50 mail service	Not covered	<u>Deductible</u> waived. <u>Prescription drug out-of-pocket limits</u> are \$2,400 per person up to \$4,800 per family. *Some generics are available at lower cost at Southcoast Pharmacies.
	Preferred brand drugs (Tier 2)	<b>Southcoast Pharmacies</b> \$30 up to 30 days' supply \$75 up to 90 days' supply	<b>CVS/Caremark</b> \$60 retail network \$150 mail service		
	Non-preferred brand drugs (Tier 3)	<b>Southcoast Pharmacies</b> \$75 up to 30 days' supply \$187.50 up to 90 days' supply	<b>CVS/Caremark</b> \$120 retail network \$300 mail service		
	<u>Specialty</u> drugs (Tier 4)	<b>Southcoast Pharmacies</b> \$50 Generic \$100 Preferred Brand \$250 Non-preferred Brand	<b>CVS/Caremark Specialty</b> \$275 Generic \$275 Preferred Brand \$250 Non-preferred Brand		
Note 1-- 90-day supplies of maintenance medications may be filled at Southcoast Pharmacy (for lowest cost), CVS Caremark Mail Order Service or any other network pharmacy. Note 2--Certain prescriptions require "clinical prior authorization" or approval from the <u>plan</u> before they will be covered.					
<b>If you have outpatient surgery</b>	Facility fee (e.g. ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> may be required or you pay \$250 more.
	Physician/Surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Not covered	



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		Southcoast Hospitals & Physician Network [Tier 1]	Preferred Providers [Tier 2]	Excluded Facilities, Steward/Out-Of-Network Providers [Tier 3]	
		(You pay the least)	(You may pay more)	(You pay the most)	
If you need immediate medical attention	Emergency room care	\$200 <u>copay/visit</u> ; <u>deductible</u> waived			<u>Copay</u> waived if admitted
	Emergency medical transportation	No charge; <u>deductible</u> waived			None
	Urgent care	\$40 <u>copay/visit</u> ; <u>deductible</u> waived	40% <u>coinsurance</u> after Tier 2 <u>deductible</u>		None
If you have a hospital stay	Facility fee (hospital room)	<u>deductible</u> only	40% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> required or you pay \$250 more.
	Physician/Surgeon fees	<u>deductible</u> only	40% <u>coinsurance</u>	40% <u>coinsurance</u> after Tier 2 <u>deductible</u> for emergency services provided at non-Steward facility	
If you need mental health, behavioral health/substance abuse services	Outpatient services— Office Visit Intensive Outpatient Treatment	\$40 <u>copay/visit</u> ; <u>deductible</u> waived No charge; <u>deductible</u> waived		\$20 <u>copay/visit</u> Not covered	<u>Preauthorization</u> required for Intensive Outpatient Treatment & Inpatient services (or you pay \$250 more).
	Inpatient services	<u>deductible</u> only		Not covered	
If you are pregnant	Office visits	\$40 <u>copay</u> for initial visit then	40% <u>coinsurance</u>	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge ( <u>deductible</u> waived)			
	Childbirth/delivery facility services	<u>deductible</u> only	40% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge; <u>deductible</u> waived	40% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> required after 8 visits
	Rehabilitation services— Inpatient	<u>deductible</u> only	40% <u>coinsurance</u>	Not covered	60 days/yr. <u>Preauthorization</u> required for Inpatient or you pay \$250 more. 100 visits/yr combined for Occupational, Physical, Speech & TMJ therapies ( <u>preauthorization</u> required after 8 visits/yr each)
	Outpatient	\$40 <u>copay/visit</u> ; <u>deductible</u> waived	40% <u>coinsurance</u>	Not covered	



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		Southcoast Hospitals & Physician Network [Tier 1]	Preferred Providers [Tier 2]	Excluded Facilities, Steward/Out-Of-Network Providers [Tier 3]	
		(You pay the least)	(You may pay more)	(You pay the most)	
If you need help recovering or have other special health needs (continued)	Habilitation services— Early Intervention	\$40 <u>copay</u> /visit; <u>deductible</u> waived	40% <u>coinsurance</u>	Not covered	Up to age 3
	Developmental Delay	\$40 <u>copay</u> /visit; <u>deductible</u> waived	40% <u>coinsurance</u>	Not covered	None
	Skilled nursing care	Not available	40% <u>coinsurance</u>	Not covered	100 days/yr. <u>Preauthorization</u> required or you pay \$250 more
	Durable medical equipment	Not available	40% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> required for rental over 3 months, TENS units & equipment over \$1,500
	Hospice services	No charge; <u>deductible</u> waived	40% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> required
If your child needs dental or eye care	Children’s eye exam	\$35 <u>copay</u> /visit; <u>deductible</u> waived		Not covered	1 exam/2 years
	Children’s glasses	Not covered	Not covered	Not covered	n/a
	Children’s dental check-up	Not covered	Not covered	Not covered	n/a

**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.)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Dental care (routine child &amp; adult)</li> <li>Private duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic care</li> <li>Long term care</li> <li>Routine foot care</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic surgery</li> <li>Non-emergency care when traveling outside U.S.</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Routine eye care (adults--1 exam/2 years)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids (\$2,000/36 months/ear to age 21)</li> <li>Weight loss programs (when provided by Southcoast Hospital)</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment (3 cycles/lifetime; 3 more if successful pregnancy)</li> </ul>

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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 1-877-234-5550.

**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, you can contact the plan at 1-877-234-5550. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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 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 1-877-234-5550

Portuguese (Português): De assistência em Português, ligue 1-877-234-5550

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-234-5550

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

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 \$1,700
- Specialist copayment \$50
- Hospital (facility) deductible
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,700
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,770</b>

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

- The plan's overall deductible \$1,700
- Specialist copayment \$50
- Hospital (facility) deductible
- Other no charge

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>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$720</b>

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

- The plan's overall deductible \$1,700
- Specialist copayment \$50
- Hospital (facility) deductible
- Other copayment \$40

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>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$800</b>