

 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>	Calendar Year <u>deductibles</u> : Tier 1—\$200 Individual/\$500 Employee + Dependent(s) Tier 2---\$1,700 Individual/\$3,000 Employee + Dependent(s) Tier 3---\$3,200 Individual/\$6,500 Employee + Dependent(s)	Generally, you must pay all costs from <u>providers</u> up to <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 total amount of <u>deductible</u> expenses paid by all family members meets overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Tiers 1 & 2--Yes. <u>Preventive services</u> , physician office visits and routine vision exams are some of services covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met <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> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	Tier 1---\$2,250 Individual/\$4,500 Employee + Dependent(s) Tier 2---\$4,000 Individual/\$8,000 Employee + Dependent(s) Tier 3---\$6,150 Individual/\$12,300 Employee + Dependent(s)	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.
<b>What is not included in the out-of-pocket limit?</b>	<u>Preauthorization</u> penalties, <u>premiums</u> , <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://southcoasthealthplan.org">southcoasthealthplan.org</a> or call 1-877-234-5550 for a list of <u>network providers</u> .	You pay the least if you use a Tier 1 <u>provider</u> . You may pay more if you use a Tier 2 or 3 <u>provider</u> . You pay the most if you use an <u>out-of-network provider</u> (Tier 4) and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge 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.
<b>Do you need a referral to see a specialist?</b>	No.	You may see a <u>specialist</u> you choose without a <u>referral</u> .

Note: Health Management Programs: For services related to Oncology care management, Southcoast has a care management program in place that requires a member to have a 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 & Physicians Network [Tier 1]	Preferred Providers [Tier 2]	Non-Preferred Hospitals [Tier 3]	Out-of-Network [Tier 4]	
		(You pay the least)	(You may pay more)		(You pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury/illness*	\$20 <u>copay</u> /visit; <u>deductible</u> waived	\$40 <u>copay</u> /visit;** <u>deductible</u> waived	40% <u>coinsurance</u>	40% <u>coinsurance</u> after Tier 3 <u>deductible</u> for Steward Physician charges.	* <u>Preauthorization</u> required for Tiers 2, 3 oncologist/hematologist visits. **\$30 <u>copay</u> /visit for Pediatrician.
	<u>Specialist</u> visit*	\$30 <u>copay</u> /visit; <u>deductible</u> waived	\$50 <u>copay</u> /visit; <u>deductible</u> waived			
	<u>Preventive care/ Screening/ Immunization</u>	No charge; <u>deductible</u> waived	Primary Care: \$35 <u>copay</u> / visit; <u>deductible</u> waived Pediatrician: \$25 <u>copay</u> /visit; <u>deductible</u> waived	40% <u>coinsurance</u>	Not covered (Routine Physical Exam Steward Physician charges covered @ 40% <u>coinsurance</u> after Tier 3 <u>deductible</u> )	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge; <u>deductible</u> waived	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> required for Imaging or you pay \$250 more. *includes nuclear cardiology services
	Imaging* (CT/PET scans, MRI, MRA)					
If you need drugs to treat your illness or condition. More information about <u>prescription drug coverage</u> is available at <a href="http://www.southcoasthealthplan.org">www.southcoasthealthplan.org</a>	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.					

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 & Physicians Network [Tier 1]	Preferred Providers [Tier 2]	Non-Preferred Hospitals [Tier 3]	Out-of-Network [Tier 4]	
		(You pay the least)	(You may pay more)		(You pay the most)	
If you have outpatient surgery	Facility fee (ambulatory surgery center)	<u>deductible only</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> required or you pay \$250 more
	Physician/surgeon fees	<u>deductible only</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Not covered	
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay/visit</u> ; <u>deductible</u> waived				<u>Copay</u> waived if admitted
	<u>Emergency medical transportation</u>	No charge; <u>deductible</u> waived				None
	<u>Urgent care</u>	\$20 <u>copay/visit</u> ; <u>deductible</u> waived	\$40 <u>copay/visit</u> ; <u>deductible</u> waived	40% <u>coinsurance</u> after Tier 3 <u>deductible</u>		None
If you have a hospital stay	Facility fee (e.g., hospital room)	<u>deductible only</u>	<u>deductible only</u>	40% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> required or you pay \$250 more
	Physician/surgeon fees	No charge; <u>deductible</u> waived		40% <u>coinsurance</u>	40% <u>coinsurance</u> after Tier 3 <u>deductible</u> for emergency services provided at non-Steward facility	
If you need mental health, behavioral health or substance abuse services	Outpatient services— Office Visit Intensive outpatient treatment	\$20 <u>copay/visit</u> ; <u>deductible</u> waived				<u>Preauthorization</u> required for Intensive outpatient treatment
		No charge; <u>deductible</u> waived			Not covered	
	Inpatient services	No charge; <u>deductible</u> waived			Not covered	<u>Preauthorization</u> required or you pay \$250 more
If you are pregnant	Office visits	No charge; <u>deductible</u> waived	\$40 <u>copay</u> for initial visit then No charge; <u>deductible</u> waived	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					
	Childbirth/delivery facility services	<u>deductible only</u>	<u>deductible only</u>	40% <u>coinsurance</u>	Not covered	

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 & Physicians Network [Tier 1]	Preferred Providers [Tier 2]	Non-Preferred Hospitals [Tier 3]	Out-of-Network [Tier 4]	
		(You pay the least)	(You may pay more)		(You pay the most)	
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
	<u>Rehabilitation services</u> — Inpatient	<u>deductible</u> only	<u>deductible</u> only	40% <u>coinsurance</u>	Not covered	60 days/yr. Requires <u>preauthorization</u> for Inpatient or you pay \$250 more. 100 visits/yr combined for Physical, Occupational, Speech & TMJ therapies. Requires <u>preauthorization</u> after 8 visits/yr each.
		Outpatient	\$20 <u>copay</u> /visit; <u>deductible</u> waived	\$40 <u>copay</u> /visit; <u>deductible</u> waived	40% <u>coinsurance</u>	
	<u>Habilitation services</u> -- Early Intervention	\$20 <u>copay</u> /visit; <u>deductible</u> waived	\$40 <u>copay</u> /visit; <u>deductible</u> waived	40% <u>coinsurance</u>	Not covered	Up to age 3
		Developmental Delay	\$20 <u>copay</u> /visit; <u>deductible</u> waived	\$40 <u>copay</u> /visit; <u>deductible</u> waived	40% <u>coinsurance</u>	Not covered
	<u>Skilled nursing care</u>	Not available	<u>deductible</u> only	40% <u>coinsurance</u>	Not covered	100 days/yr. Requires <u>preauthorization</u> or you pay \$250 more
	<u>Durable medical equipment</u>	Not available	20% <u>coinsurance</u> ; <u>deductible</u> waived	40% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> required for rental over 3 months, TENS units & equipment over \$1,500.
<u>Hospice services</u>	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/yr
	Children's glasses	Not covered				n/a
	Children's dental check-up	Not available		No charge; <u>deductible</u> waived	Not covered	2 exams/yr to age 12

## 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.)

- Cosmetic surgery
- Non-emergency care when traveling outside U.S.
- Dental care (routine over age 12)
- Private duty nursing
- Long term care
- Routine foot care

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

- Acupuncture (12 visits/yr)
- Hearing aids (\$2,000/ear/36 months to age 21)
- Weight loss programs (when provided by Southcoast Hospital)
- Bariatric surgery
- Infertility treatment (3 cycles/lifetime; 3 more if successful pregnancy)
- Chiropractic care (12 visits/yr)
- Routine eye care (adults--1 exam/yr)

**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 \$200
- Specialist copayment \$30
- Hospital (facility) deductible
- Other deductible

**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	\$200
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$270</b>

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

- The plan's overall deductible \$200
- Specialist copayment \$30
- 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	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$520</b>

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

- The plan's overall deductible \$200
- Specialist copayment \$30
- Hospital (facility) deductible
- Other copayment \$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*)

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$460</b>