**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 or call 1-877-234-5550 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Calendar Year deductibles:<br>Tier 1—$300 Individual/$700 Employee + Dependent(s)<br>Tier 2---$2,000 Individual/$4,000 Employee + Dependent(s)<br>Tier 3---$3,500 Individual/$7,000 Employee + Dependent(s) | Generally, you must pay all costs from providers up to 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 total amount of deductible expenses paid by all family members meets overall family deductible. |
| **Are there services covered before you meet your deductible?** | Tiers 1 & 2--Yes. Preventive services, physician office visits and routine vision exams are some of services covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met 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 healthcare.gov/coverage /preventive-care-benefits. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Tier 1---$3,000 Individual/$6,000 Employee + Dependent(s)<br>Tier 2---$5,000 Individual/$10,000 Employee + Dependent(s)<br>Tier 3---$6,200 Individual/$12,400 Employee + Dependent(s) | 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 is met. |
| **What is not included in the out-of-pocket limit?** | Preauthorization penalties, premiums, balance-billing charges and health care this plan doesn't cover. | 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 southcoasthealthplan.org or call 1-877-234-5550 for a list of network providers. | You pay the least if you use a Tier 1 provider. You may pay more if you use a Tier 2 or 3 provider. You pay the most if you use an out-of-network provider (Tier 4) 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 may see a specialist you choose without a referral. |

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. Limited coverage is available for providers formerly known as Steward Medical Group. Physician office visits may be covered at Tier 4. All other services related to the visit or billed as part of the visit are excluded. The following facilities are not covered under any plan except for emergencies: St. Anne's Hospital, Morton Hospital, Good Samaritan Medical Center, St. Elizabeth's Medical Center and Holy Family Hospitals.

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 copay/visit; deductible waived | $40 copay/visit;** deductible waived | 40% coinsurance | 40% coinsurance after Tier 3 deductible for Steward Physician charges. | *Preauthorization required for Tiers 2, 3 oncologist/hematologist visits. **$30 copay/visit for Pediatrician. |
| | Specialist visit* | $30 copay/visit; deductible waived | $50 copay/visit; deductible waived | | | |
| | Preventive care/ Screening/ Immunization | No charge; deductible waived | Primary Care: $35 copay/ visit; deductible waived<br>Pediatrician: $40 copay/ visit; deductible waived | 40% coinsurance | Not covered (Routine Physical Exam Steward Physician charges covered @ 40% coinsurance after Tier 3 deductible) | You may have to pay for services that aren't preventive. Ask provider if services are preventive. Check what plan will pay. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge; deductible waived | 10% coinsurance | 40% coinsurance | Not covered | Preauthorization required for Imaging or you pay $250 more.<br>*includes nuclear cardiology services |
| | Imaging* (CT/PET scans, MRI, MRA) | | 20% coinsurance | | | |
| **If you need drugs to treat your illness or condition.** More information about **prescription drug coverage** is available at southcoasthealthplan.org | Generic drugs (Tier 1) | **Southcoast Pharmacies**<br>$10* up to 30 days' supply<br>$25* up to 90 days' supply | | **CVS/Caremark**<br>$25 retail network<br>$62.50 mail service | Not covered | Deductible waived.<br>Prescription drug out-of-pocket limits are $3,000 per person up to $6,000 per family.<br>*Some generics are available at lower cost at Southcoast Pharmacies.<br>**Coinsurance waived if specialty drug is eligible & member enrolls in CVS Caremark's PrudentRx Program. |
| | Preferred brand drugs (Tier 2) | **Southcoast Pharmacies**<br>$50 up to 30 days' supply<br>$125 up to 90 days' supply | | **CVS/Caremark**<br>$100 retail network<br>$250 mail service | | |
| | Non-preferred brand drugs (Tier 3) | **Southcoast Pharmacies**<br>$75 up to 30 days' supply<br>$187.50 up to 90 days' supply | | **CVS/Caremark**<br>$140 retail network<br>$350 mail service | | |
| | Specialty drugs (Tier 4) | **Southcoast Specialty**<br>30% coinsurance | | **CVS Specialty**<br>30% coinsurance** | | |
| | 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 plan 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) | No charge; deductible waived | 20% coinsurance | 40% coinsurance | Not covered | Preauthorization may be required or you pay $250 more. |
| | Physician/surgeon fees | deductible only | 20% coinsurance | 40% coinsurance | Not covered | |
| **If you need immediate medical attention** | Emergency room care | $200 copay/visit; deductible waived | | | | Copay waived if admitted |
| | Emergency medical transportation | No charge; deductible waived | | | | None |
| | Urgent care | $25 copay/visit; deductible waived | $45 copay/visit; deductible waived | 40% coinsurance after Tier 3 deductible | | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | deductible only | 10% coinsurance | 40% coinsurance | Not covered | Preauthorization required or you pay $250 more |
| | Physician/surgeon fees | No charge; deductible waived | 10% coinsurance; deductible waived | 40% coinsurance | 40% coinsurance after Tier 3 deductible for emergency services provided at non-Steward facility | |
| **If you need mental health, behavioral health or substance abuse services** | Outpatient services—Office Visit | $20 copay/visit; deductible waived | | | | Preauthorization required for Intensive outpatient treatment |
| | Intensive outpatient treatment | No charge; deductible waived | | | Not covered | |
| | Inpatient services | deductible only | | | Not covered | Preauthorization required or you pay $250 more |
| **If you are pregnant** | Office visits | No charge; deductible waived | $40 copay for initial visit then No charge; deductible waived | 40% coinsurance | 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 | deductible only | 10% coinsurance | 40% coinsurance | 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; deductible waived | | 40% coinsurance | Not covered | Preauthorization required after 12 weeks |
| | Rehabilitation services— Inpatient | deductible only | 10% coinsurance | 40% coinsurance | Not covered | 60 days/yr. Requires preauthorization for Inpatient or you pay $250 more. 100 visits/yr combined for Physical, Occupational, Speech & TMJ therapies. Requires preauthorization after 12 weeks each for Physical & Occupational therapies and after 6 visits for Speech therapy. |
| | Outpatient | $20 copay/visit; deductible waived | $40 copay/visit; deductible waived | 40% coinsurance | Not covered | |
| | Habilitation services-- Early Intervention | $20 copay/visit; deductible waived | $40 copay/visit; deductible waived | 40% coinsurance | Not covered | Up to age 3 |
| | Developmental Delay | $20 copay/visit; deductible waived | $40 copay/visit; deductible waived | 40% coinsurance | Not covered | None |
| | Skilled nursing care | No charge; deductible waived | 10% coinsurance | 40% coinsurance | Not covered | 100 days/yr. Requires preauthorization or you pay $250 more |
| | Durable medical equipment | Not available | 20% coinsurance; deductible waived | 40% coinsurance | Not covered | Preauthorization required for rental over 3 months, TENS units & equipment over $2,500. |
| | Hospice services | No charge; deductible waived | | 40% coinsurance | Not covered | Preauthorization required |
| **If your child needs dental or eye care** | Children's eye exam | $35 copay/visit; deductible waived | | | Not covered | 1 exam/yr |
| | Children's glasses | Not covered | | | | n/a |
| | Children's dental check-up | No charge; deductible waived | | Not covered | 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 | • Dental care (routine over age 12) | • Long term care |
| • Non-emergency care when traveling outside U.S. | • Private duty nursing | • 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) | • Bariatric surgery | • Chiropractic care (12 visits/yr) |
| • Hearing aids ($2,000/ear/36 months to age 21) | • Infertility treatment ($40,000/lifetime Medical;$20,000/lifetime Rx) | • Routine eye care (adults--1 exam/yr) |
| • Weight loss programs (when provided by Southcoast Hospital) | | |

**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. 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 or call 1-800-318-2596.

**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 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.

**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 assistència 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** **$300**
- **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)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $10 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$370** |

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

- **The plan's overall deductible** **$300**
- **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)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$520** |

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

- **The plan's overall deductible** **$300**
- **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)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $400 |
| Coinsurance | $60 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$460** |