



**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](https://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> are: Tier 1—\$400 Individual/\$800 Employee + Dependent(s) Tier 2---\$2,000 Individual/\$4,000 Employee + Dependent(s) Tier 3---\$3,500 Individual/\$7,000 Employee + Dependent(s) Tier 4—\$5,000 Individual/\$10,000 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 deductible.
<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="https://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—\$3,100 Individual/\$6,200 Employee + Dependent(s) Tier 2---\$5,000 Individual/\$10,000 Employee + Dependent(s) Tier 3---\$6,200 Individual/\$12,400 Employee + Dependent(s) Tier 4---\$9,000 Individual/\$18,000 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="https://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 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 & Providers [Tier 3]	Out-of-Network Hospitals & Providers [Tier 4]	
		(You pay the least)	(You may pay more)		(You may 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>	50% <u>coinsurance</u>	* <u>Preauthorization</u> required for visits to Tiers 2, 3, & 4 oncologist or hematologist **\$40 <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	40% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>Screening</u> / Immunization	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>	50% <u>coinsurance</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	10% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for Imaging or you pay \$250 more. *includes nuclear cardiology
	Imaging* (CT/PET scans, MRI, MRA)	No charge; <u>deductible</u> waived	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need drugs to treat your illness or condition.  More information about <u>prescription drug coverage</u> is available at southcoasthealthplan.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> \$25 retail network \$62.50 mail service		<u>Deductible</u> waived. <u>Prescription drug out-of-pocket limits</u> are \$3,000 per person up to \$6,000 per family. *Some generics are available at lower cost at Southcoast Pharmacies. ** <u>Coinsurance</u> waived if <u>specialty</u> drug is eligible & member enrolls in CVS Caremark's PrudentRx Program.
	Preferred brand drugs (Tier 2)	<b>Southcoast Pharmacies</b> \$50 up to 30 days' supply \$125 up to 90 days' supply		<b>CVS/Caremark</b> \$100 retail network \$250 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> \$140 retail network \$350 mail service		
	<u>Specialty</u> drugs (Tier 4)	<b>Southcoast Specialty</b> 30% <u>coinsurance</u>		<b>CVS Specialty</b> 30% <u>coinsurance</u> **		
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.						



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		Southcoast Hospitals & Physicians Network [Tier 1]	Preferred Providers [Tier 2]	Non-Preferred Hospitals & Providers [Tier 3]	Out-of-Network Hospitals & Providers [Tier 4]	
		(You pay the least)	(You may pay more)		(You may 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>	50% <u>coinsurance</u>	Preauthorization may be required or you pay \$250 more.
	Physician/surgeon fees	<u>deductible only</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	Emergency room care	\$200 <u>copay/visit</u> ; <u>deductible waived</u>				Copay waived if admitted
	Emergency medical transportation	No charge; <u>deductible waived</u>				None
	Urgent care	\$30 <u>copay/visit</u> ; <u>deductible waived</u>	\$50 <u>copay/visit</u> ; <u>deductible waived</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	<u>deductible only</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization required or you pay \$250 more
	Physician/surgeon fees	No charge; <u>deductible waived</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need mental health, behavioral health or substance abuse services	Outpatient services— Office Visit	\$20 <u>copay/visit</u> ; <u>deductible waived</u>	\$20 <u>copay/visit</u> ; <u>deductible waived</u>	\$20 <u>copay/visit</u> ; <u>deductible waived</u>	50% <u>coinsurance</u>	Preauthorization required for Intensive outpatient treatment
	Intensive outpatient treatment	No charge; <u>deductible waived</u>	No charge; <u>deductible waived</u>	No charge; <u>deductible waived</u>	50% <u>coinsurance</u>	
	Inpatient services	<u>deductible only</u>	<u>deductible only</u>	<u>deductible only</u>	50% <u>coinsurance</u>	Preauthorization required or you pay \$250 more
If you are pregnant	Office visits	No charge; <u>deductible waived</u>	Prenatal: \$40 <u>copay/initial visit</u> ; Then all other visits: No charge; <u>deductible waived</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	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>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	

Failure to obtain prior precertification for Medically Necessary procedures will result in a reduction in benefits in the amount of \$250 per occurrence, unless otherwise noted.  
 Failure to obtain prior precertification for Oncology Treatment (including Office Visits) by a Tier 2 or 3 provider for patients age 18 years or older by Conifer Health Solutions will result in a \$500 penalty.



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 & Providers [Tier 3]	Out-of-Network Hospitals & Providers [Tier 4]	
		(You pay the least)	(You may pay more)		(You may pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge; deductible waived	No charge; deductible waived	40% coinsurance	50% coinsurance	Preauthorization required after 12 weeks
	Rehabilitation services— Inpatient	deductible only	20% coinsurance	40% coinsurance	50% coinsurance	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	50% coinsurance	
	Habilitation services-- Early Intervention	\$20 copay/visit; deductible waived	\$40 copay/visit; deductible waived	40% coinsurance	50% coinsurance	Up to age 3
	Developmental Delay	\$20 copay/visit; deductible waived	\$40 copay/visit; deductible waived	40% coinsurance	50% coinsurance	None
	Skilled nursing care	deductible only	20% coinsurance	40% coinsurance	50% coinsurance	100 days/yr. Requires preauthorization or you pay \$250 more
	Durable medical equipment	Not available	20% coinsurance; deductible waived	40% coinsurance	50% coinsurance	Preauthorization required for rental over 3 months, TENS units & equipment over \$2,500.
	Hospice services	No charge; deductible waived		40% coinsurance	50% coinsurance	Preauthorization required
Failure to obtain prior precertification for Medically Necessary procedures will result in a reduction in benefits in the amount of \$250 per occurrence, unless otherwise noted. Failure to obtain prior precertification for Oncology Treatment (including Office Visits) by a Tier 2 or 3 provider for patients age 18 years or older by Conifer Health Solutions will result in a \$500 penalty.						



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		(You pay the least)	(You may pay more)		(You may pay the most)	
If your child needs dental or eye care	Children's eye exam	\$35 <u>copay</u> /visit; <u>deductible</u> waived			50% <u>coinsurance</u>	1 exam/yr
	Children's glasses	Not covered				n/a
	Children's dental check-up	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 <u>plan</u> document for more information and a list of any other excluded services.)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Non-emergency care when traveling outside U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (routine over age 12)</li> <li>• Private duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Long term care</li> <li>• Routine foot care</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture (12 visits/yr)</li> <li>• Hearing aids (\$2,000/aid/ear/36 months to age 21)</li> <li>• Weight loss programs (when provided by Southcoast Hospital)</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Infertility treatment (\$40,000/lifetime Medical; \$20,000/lifetime Rx)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care (12 visits/yr)</li> <li>• Routine eye care (adults--1 exam/yr)</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 1-800-318-2596.

**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](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 <u>deductible</u>	\$400
■ Specialist <u>copayment</u>	\$30
■ Hospital (facility) <u>deductible</u>	
■ Other <u>deductible</u>	

#### 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:

Cost Sharing	
Deductibles	\$400
Copayments	\$10
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$470</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$400
■ Specialist <u>copayment</u>	\$30
■ Hospital (facility) <u>deductible</u>	
■ Other <i>no charge</i>	

#### 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:

Cost Sharing	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$200
What isn't covered	
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 <u>deductible</u>	\$400
■ Specialist <u>copayment</u>	\$30
■ Hospital (facility) <u>deductible</u>	
■ Other <u>copayment</u>	\$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:

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