Extended Care – Bronze Plan

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Coverage Period: 08/01/2023 – 07/31/2024
Coastal Administrative Services: Medical Plan
Coverage for: EE/EE+SP/EE+CH(n)/FAM | **Plan Type:** PPO

1The 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 CAS at 855-373-8232. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.casbenefits.com or call 1-855-373-8232 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers: $6,350 individual / $12,700 family For out-of-network providers: $12,700 individual / $25,400 family	Generally, you must pay all of the costs from providers up to the 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 the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers: $6,350 individual / $12,700 family For out-of-network providers: $30,000 individual / $60,000 family	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 has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed 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 www.casbenefits.com or call 855-373-8232 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, 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 do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 copay/visit, then 100% deductible waived	20% copay/visit, 20% coinsurance after deductible	
	Specialist visit	$0 copay/visit, deductible waived	20% copay/visit, 20% coinsurance after deductible	
	Preventive care/screening/ immunization	No Charge	No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (blood work)	No Charge after deductible	20% coinsurance after deductible	
	CT/PET scans, MRIs	No Charge after deductible	20% coinsurance after deductible	Preauthorization is required.
	Diagnostic Imaging (X-rays)	No Charge after deductible	20% coinsurance after deductible	Preauthorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ehimrx.com	Generic drugs (Tier 1)	No Charge after deductible		Covers up to a 90-day retail supply (1 copay per 90-day supply); 90-day mail order supply.
	Preferred brand drugs (Tier 2)	No Charge after deductible		
	Non-preferred brand drugs (Tier 3)	No charge after deductible		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible	20% coinsurance after deductible	Preauthorization is required.
	Physician/surgeon fees	No Charge after deductible	20% coinsurance after deductible	Preauthorization is required.
If you need immediate medical attention	Emergency room care	No Charge after deductible	20% coinsurance after deductible	
	Emergency medical transportation	No Charge after deductible	20% coinsurance after deductible	
	Urgent care	$0 copay/visit, then 100% deductible waived	20% copay/visit, 20% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	20% coinsurance after deductible	Preauthorization is required for inpatient hospital stays
	Physician/surgeon fees	No Charge after deductible	20% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 copay/visit, then 100% deductible waived	20% copay/visit, 20% coinsurance after deductible	Copayments apply to the office visit charge only. Any other services covered under the plan are subject to deductible and coinsurance. Pre-authorization is required for facility services
	Inpatient services	No Charge after deductible	20% coinsurance after deductible	Preauthorization is required for inpatient services.
If you are pregnant	Office visits	$0 copay/visit, then 100% deductible waived	20% copay/visit, 20% coinsurance after deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is required for facility charges.
	Childbirth/delivery professional services	No Charge after deductible	20% coinsurance after deductible	
	Childbirth/delivery facility services	No Charge after deductible	20% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	No Charge after deductible	20% coinsurance after deductible	Preauthorization is required
	Rehabilitation services	$0 copay/visit, then 100% deductible waived	20% copay/visit, 20% coinsurance after deductible	20 visits/calendar year
	Habilitation services	No Charge after deductible	20% coinsurance after deductible	
	Skilled nursing care	No Charge after deductible	20% coinsurance after deductible	Preauthorization is required
	Durable medical equipment	No Charge after deductible	20% coinsurance after deductible	
	Hospice services	No Charge after deductible	20% coinsurance after deductible	Preauthorization is required

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 • Infertility Treatment	• Long Term Care • Weight loss programs.	• Private Duty Nursing • Routine Foot Care • Bariatric Surgery

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Physical Therapy	• Orthotics	• Durable Medical Equipment

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 1-866-444-3272 or https://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, contact: 1-855-373-8232

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-855-373-8232

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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	$6,350
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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*	$6,350
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,410**

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

The plan's overall deductible	$6,350
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$5,640**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,200
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,760**

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

The plan's overall deductible	$6,350
Emergency Room copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$2,810**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$2,800
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,810**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.