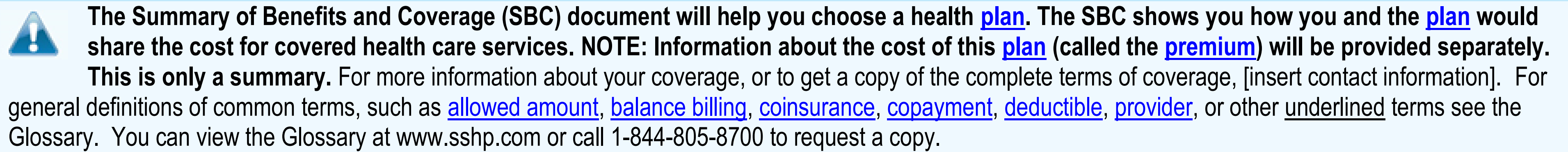
SEASIDE HEALTH PLAN
An Affiliate of MemorialCare

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Coverage Period: 01/01/2018 – 12/31/2018
Seaside Health Plan: Select
Coverage for: Individual/Family | **Plan Type:** HMO



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, [insert contact information]. 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.sshp.com or call 1-844-805-8700 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0.**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	**$ 0**	You don't have to meet deductibles for specific services, but see the chart for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	**$2,000 Individual** **$4,000 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. This limit helps you plan for health care expenses through the end of the calendar year.
What is not included in the out-of-pocket limit?	Copayments for certain services, 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 www.SSHP.com or call 1-844-805-8700 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. Seaside Health Plan is an affiliate of the MemorialCare Medical Group, Greater Newport Physician (excluding the Hoag Pod), Saddleback Medical Center, Orange Coast Medical Center, Miller Children's & Women's

		Hospital Long Beach, Long Beach Medical Center, Community Medical Center, and a network of contracted community based providers.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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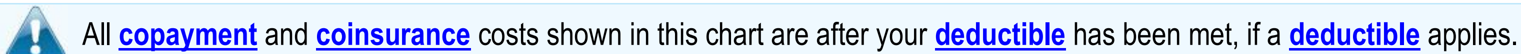

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

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	Not Covered	None
	Specialist visit	$0 copay/Visit	Not Covered	None
	Chiropractic/ Acupuncture visit	$15 copay/ Visit for Chiropractic rider $15 Copay/Visit for Acupuncture rider	Not Covered	Coverage is limited to 30 visits per calendar year
	Preventive care/screening/ immunization	$0 copay/Visit	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	$0 copay/Visit	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$0 copay/Visit	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.SSHP.com	Generic drugs (Tier 1)	$15 copay/Prescription for Retail Pharmacy $30 copay/Prescription for Home Delivery Program	50% of the remaining prescription drug allowed amount less any pharmacy deductible (if applicable), the above retail pharmacy copay and costs in excess of the prescription drug maximum allowed amount	30-day supply, 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/ 30-day period for impotence and/or sexual dysfunction drug for Retail Program 90-day Supply for Home Delivery program.
	Preferred brand drugs (Tier 2)	$35 copay/Prescription for Retail Pharmacy $70 copay/Prescription Home Delivery Program	50% of the remaining prescription drug allowed amount less any pharmacy deductible (if applicable), the above retail pharmacy copay and costs in excess of the prescription drug maximum allowed amount.	30-day supply, 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/ 30-day period for impotence and/or sexual dysfunction drug for Retail Program 90-day Supply for Home Delivery program.
	Non-preferred brand drugs (Tier 3)	$50 copay/Prescription for Retail Pharmacy $100 copay/Prescription Home Delivery Program	50% of the remaining prescription drug allowed amount less any pharmacy deductible (if applicable), the above retail pharmacy	30-day supply, 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/ 30-day period for impotence and/or sexual

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)	
			copay and costs in excess of the prescription drug maximum allowed amount.	dysfunction drug for Retail Program 90-day Supply for Home Delivery program.
	Specialty drugs	$50 copay/Prescription for Retail Pharmacy $100 copay/Prescription Home Delivery Program	Not Covered	30-day Supply for Specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 copay/Visit	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room care	$0 copay/Visit	$0 copay/Visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$0 copay/Visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$0 copay/Admit	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	Not Covered	Failure to obtain pre-authorization may result in non-coverage or reduced benefits.
	Inpatient services	$0 copay/Visit	Not Covered	Failure to obtain pre-authorization may result in non-coverage or reduced benefits.
If you are pregnant	Office visits	$0 copay/Visit	Not Covered	None
	Childbirth/delivery professional services	No Charge	Not Covered	None
	Childbirth/delivery facility services	No Charge	Not Covered	None
If you need help recovering or have other special health needs	Home health care	$0 copay/Visit	Not Covered	None
	Rehabilitation services	$0 copay/Visit	Not Covered	None
	Habilitation services	$0 copay/Visit	Not Covered	None
	Skilled nursing care	No Charge	Not Covered	None

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)	
	Durable medical equipment	No Charge	Not Covered	None
	Hospice services	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Covered under preventative	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the US
- Private Duty Nursing
- Routine eye care
- Routine foot care
- Weight loss programs

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

- Acupuncture- $15 per visit, 30 visits per calendar year (combined) through American specialty Health Plan (ASH)
- Chiropractic care- $15 per visit, 30 visits per calendar year (combined) through American specialty Health Plan (ASH)
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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: Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at (877) 267-2323 x61565 or cciio.cms.gov. 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:

Seaside Health Plan at (844) 805-8700 2840 Long Beach Blvd, Ste #120; Long Beach, CA 90806 Attn: Grievances.

Additionally, a consumer assistance program can help you file your appeal. Contact: California Department of Managed health Care Help Center: 980 9th Street, Suite 500 Sacramento, CA 95814 (888) 466-2219; http://www.healthhelp.ca.gov helpline@dmhc.ca.gov

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 the 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 (844) 805-8700.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (844) 805-8700.
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (844) 805-8700.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (844) 805-8700.

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** $0
- **Specialist *[cost sharing]*** $0
- **Hospital (facility) *[cost sharing]*** 0%
- **Other *[cost sharing]*** 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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

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

- **The plan's overall deductible** $0
- **Specialist *[cost sharing]*** $0
- **Hospital (facility) *[cost sharing]*** 0%
- **Other *[cost sharing]*** 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	**$7,400**

In this example, Joe would pay:

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

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

- **The plan's overall deductible** $0
- **Specialist *[cost sharing]*** $0
- **Hospital (facility) *[cost sharing]*** 0%
- **Other *[cost sharing]*** 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	**$2,500**

In this example, Mia would pay:

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

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