MEDICAL INSURANCE PLAN COMPARISON

SOUTH COUNTY HEALTH

2026/2027 Medical Plan Cost Comparison

Full-Time Staff (36–40 hours per week)**						
Rate of Pay	**Coverage Level**	**2026 PPO**	**2027 Premier Choice**	**2027 EPO**	**2026 HDHP**	**2027 HDHP**
Up to $24.03 per hour (Up to $49,999 per year*)	**Single Plan**	*$69.51*	$57.87	$77.16	*$49.03*	$54.42
	Two Person Plan	*$139.50*	$116.13	$154.85	*$98.41*	$109.24
	Family Plan	*$159.06*	$132.42	$176.56	*$100.39*	$111.43
$24.04 to $48.07 per hour ($50,000 to $99,999 per year*)	**Single Plan**	*$76.11*	$63.36	$84.48	*$55.07*	$61.13
	Two Person Plan	*$152.70*	$127.12	$169.50	*$110.50*	$122.65
	Family Plan	*$174.57*	$145.33	$193.77	*$114.40*	$126.98
$48.08 to $96.15 per hour ($100,000 to $199,999 per year*)	**Single Plan**	*$84.59*	$70.42	$93.90	*$62.85*	$69.76
	Two Person Plan	*$169.21*	$140.87	$187.82	*$125.74*	$139.57
	Family Plan	*$195.22*	$162.52	$216.69	*$132.93*	$147.55
$96.16+ per hour ($200,000 and over per year*)	**Single Plan**	*$111.10*	$92.49	$123.32	*$89.08*	$98.88
	Two Person Plan	*$222.21*	$184.99	$246.66	*$178.17*	$197.77
	Family Plan	*$260.14*	$216.57	$288.76	*$196.94*	$218.60
Part-Time Staff (20–35 hours per week)**						
Rate of Pay	**Coverage Level**	**2026 PPO**	**2027 Premier Choice**	**2027 EPO**	**2026 HDHP**	**2027 HDHP**
Up to $24.03 per hour (Up to $49,999 per year*)	**Single Plan**	*$127.31*	$105.99	$141.31	*$106.46*	$118.17
	Two Person Plan	*$248.15*	$206.58	$275.45	*$207.52*	$230.35
	Family Plan	*$289.54*	$241.04	$321.39	*$231.89*	$257.40
$24.04 to $48.07 per hour ($50,000 to $99,999 per year*)	**Single Plan**	*$140.98*	$117.36	$156.49	*$119.58*	$132.73
	Two Person Plan	*$270.88*	$225.51	$300.68	*$229.77*	$255.05
	Family Plan	*$316.38*	$263.39	$351.18	*$258.16*	$286.56
$48.08 to $96.15 per hour ($100,000 to $199,999 per year*)	**Single Plan**	*$159.64*	$132.90	$177.20	*$137.55*	$152.68
	Two Person Plan	*$304.50*	$253.50	$337.99	*$262.36*	$291.22
	Family Plan	*$355.46*	$295.92	$394.56	*$296.00*	$328.56
$96.16+ per hour ($200,000 and over per year*)	**Single Plan**	*$218.08*	$181.55	$242.07	*$195.51*	$217.02
	Two Person Plan	*$426.00*	$354.65	$472.86	*$381.92*	$423.93
	Family Plan	*$498.18*	$414.73	$552.98	*$436.43*	$484.44

Working Spouse Medical Contributions may be found in the Benefit Guide.

* Based on 40 hours per week
** Contribution per pay period.

PPO vs. EPO vs. Premier Choice

	2026 VantageBlue PPO Staff Cost			2027 EPO Plan Staff Cost		2027 Premier Choice Plan Staff Cost	
	TIER 1 SCH NETWORK	TIER 2 BLUECARD PPO NETWORK	TIER 3 OUT-OF-NETWORK	TIER 1 SCH NETWORK	TIER 2 UNITEDHEALTHCARE CHOICE PLUS NETWORK	TIER 1 SCH NETWORK	TIER 2 OPEN NETWORK
Annual Deductible							
Individual/Family	$0	$1,500/$3,000	$1,500/$3,000	$0	$1,500/$3,000	$0	$1,500/$3,000
Out-of-Pocket Maximum							
Individual/Family	$4,000/$8,000		$8,000/$16,000	$0	$4,000/$8,000	$0	$4,000/$8,000
Office Visits							
Personal Physician	$0	$30	$30 + 30%/visit*	$0	$30	$0	$30
Preventive Visit	$0	$0	$30 + 30%/visit*	$0	$0	$0	$0
Specialist	$0	$50	$50 + 30%/visit*	$0	$50	$0	$50
Chiropractic Visits	$0	$50	$50 + 30%/visit*	Not Available	$50	Not Available	$50
Routine Eye Exam {One per Year)	$0	$50	$50 + 30%/visit*	Not Available	$50	Not Available	$50
Urgent Care	$0	$30	$30	$0	$30	$0	$30
Emergency Services							
Emergency Room Care	$200 (waived if admitted)			$200 (waived if admitted)		$200 (waived if admitted)	
Ambulance Services	$50	$50	$50	$50	$50	$50	$50
Outpatient Services							
Outpatient Hospital & Physician Services	$0	50%*	50% per visit*	$0	100%*	$0	100%*
Outpatient Surgery & Procedures	$0	20%*	30% per visit*	$0	100%*	$0	100%*
Lab Work, Preventive, Diagnostic Tests & X-rays	$0	Preventive: $0 Diagnostic: 50%*	Preventive: 30% per visit* Diagnostic: 50% per visit*	$0	100%*	$0	100%*
Cardiology Services	Not Available	20%	Not Available	Not Available	30%	Not Available	30%
Maternity Care – High Risk	$0	30%*	30% per visit*	Not Available	30%	Not Available	30%
Maternity Care – All Other	$0	50%*	50% per visit*	$0	100%*	$0	100%*
Oncology Services (Including Chemotherapy & Radiation)	$0	30%*	30% per visit*	$0	100%*	$0	100%*
Inpatient Services							
Hospitalization & Physician Services	$0	20%*	30% per visit*	$0	100%*	$0	100%*
Maternity Care – High Risk	Not Available	30%*	30% per visit*	Not Available	30%	Not Available	30%
Maternity Care – Labor & Delivery	$0	50%*	50% per visit*	$0	100%*	$0	100%*
Mental Health & Chemical Dependency Treatment Services							
Inpatient	Not Available	20%*	30%*	Not Available	20%	Not Available	20%
Outpatient	Not Available	20%*	30%*	Not Available	20%	Not Available	20%
Office Visits	$0	$0	$30 + 30%*	Not Available	$30	Not Available	$30
Diabetic Services							
Eye & Foot Exams	$0	$0	$50 + 30%*	$0	$0	$0	$0
Additional Services							
Physical Therapy	0%/visit	20%*	30%*	0%	20%	0%	20%
Occupational & Speech Therapy	0%/visit	20%*	30%*	0%	20%	0%	20%
Durable Medical Equipment (DME)	Not Available	20%*	30%*	Not Available	20%	Not Available	20%
Home & Hospice Care	$0	20%	30%*	$0	20%	$0	20%
Acupuncture (12 Visit Max)	$0	$30	$30 + 30%*	Not Available	$30	Not Available	$30

* After deductible, see footnotes on next page.

2026/2027 Medical Plan Comparison

Important Plan Footnotes

For services that SCH can provide, members are subject to a 100% coinsurance if they opt to receive services from a non-SCH provider. If you anticipate receiving services from a non-SCH provider or in a non-SCH location, please be aware that you will be subject to the coinsurance up to the Out of Pocket Maximum.

[1]Deductibles, coinsurance and flat dollar copayments (medical and prescription drug) apply to the plan year (calendar) maximum out of pocket expense.

[2]Deductible and coinsurance will not apply when physical therapy or occupational therapy services are provided at Ortho Rhode Island locations. Note physical therapy is the only Tier 1 service at South County Orthopedics. The South County Health Tier 1 Network consists of South County Hospital, South County Home Health, and South County Medical Group.

[3]Patients who require delivery prior to 35 weeks, newborns anticipated to require NICU care, certain genetic disorders, or poorly controlled maternal diabetes, type 1 DM, on therapeutic anti-coagulation, significant maternal cardiac disease (artificial valves, aortic stenosis etc.), molar pregnancies, abnoral placentation, or substance use not well controlled as determined by the provider.

[4]SCH performs colon, breast, and complex hernia surgery; 100% deductible for those services applies. Surgery including post-mastectomy reconstruction, tissue expander placement for reconstruction, as well as thyroid, parathyroid, bariatric, major liver, pancreatic, esophageal, rectal, and thoracic surgeries performed elsewhere are subject to a 30% coinsurance.

[5]Gyn oncology and extensive MIGS cases with endometriosis not available at SCH; a 30% coinsurance will apply.

[6]Endoscopy: SCH offers EGD, colonoscopy, ERCP, EUS, dilation, stenting and feeding tube placement. Services not available at SCH subject to a 30% coinsurance.

[7]Orthopedics: Orthopedic cancer surgery and pelvic or acetabular fracture surgery are performed elsewhere and subject to 30% coinsurance.

[8]Pediatric procedures performed at other healthcare systems are not subject to the 100% deductible; a 30% deductible will apply.
Esophageal manometry and pH/impedence testing (ie Bravo) is not provided at SCH; a 30% coinsurance will apply
Endoscopic Submucosal Dissection(ESD), POEM, and advanced biliary procedures are not performed at SCH; a 30% coinsurance will apply.

[9]X-ray, Imaging and Machine Tests excluded from SCH services where a 30% coinsurance applies includes:

Specialty marker sphere/calibration related to per-surgical planning for orthopedic procedures,
CT - Calcium Scoring, Cardiac/HeartFlow FFR-CT, Brain Perfusion, 3D colonoscopy, any gated Exams, or any outpatient < 14 years old,
MRI - Prostate, Cardiac, Any outpatient < 14 years old, Ultrasound - Level 2 Obstretical scans, Fetal echocardiograms, appendix, any outpatient < 8 years old, and Nuclear Medicine - SpecCT, VQ Scan, WBC/Therapies, Brain Death & DMSA.

HDHP VS. HDHP

	2026 HDHP Staff Cost			2027 HDHP Staff Cost	
	TIER 1 SCH NETWORK	TIER 2 BLUECARD PPO NETWORK	TIER 3 OUT-OF-NETWORK	TIER 1 SCH NETWORK	TIER 2 UNITEDHEALTHCARE CHOICE PLUS NETWORK
Annual Deductible					
Individual/Family	$1,700/$3,400	$3,400/$6,800		$1,750/$3,500	$3,500/$7,000
Out-of-Pocket Maximum					
Individual/Family	$3,000/$6,000	$4,000/$8,000		$4,000/$8,000	$4,000/$8,000
Office Visits					
Personal Physician	0% per visit*	20% per visit*	30% per visit*	$0*	30%*
Preventive Visit	$0	$0	30% per visit*	$0*	30%*
Specialist	0% per visit*	20% per visit*	30% per visit*	$0*	30%*
Chiropractic Visits	0% per visit*	20% per visit*	30% per visit*	Not Available	30%*
Routine Eye Exam (One per Year)	0% per visit*	20% per visit*	30% per visit*	Not Available	30%*
Urgent Care	0% per visit*	20% per visit*	30% per visit*	$0*	30%*
Emergency Services					
Emergency Room Care	$200* (waived if admitted)			$200* (waived if admitted)	
Ambulance Services	0%*	0%*	0%*	$50*	$50*
Outpatient Services					
Outpatient Hospital & Physician Services	0% per visit*	30% per visit*	30% per visit*	$0*	100%*
Outpatient Surgery & Procedures	0% per visit*	20% per visit*	30% per visit*	$0*	100%*
Lab Work, Preventive, Diagnostic Tests & X-rays	$0	Preventive: $0 Diagnostic: 50% per visit*	Preventive: 30% per visit* Diagnostic: 50% per visit*	$0*	100%*
Cardiology Services	Not Available	20%	Not Available	Not Available	30%*
Maternity Care – High Risk	0% per visit*	30% per visit*	30% per visit*	Not Available	30%*
Maternity Care – All Other	0% per visit*	50% per visit*	50% per visit*	$0*	100%*
Oncology Services (Including Chemotherapy & Radiation)	0% per visit*	30% per visit*	30% per visit*	$0*	100%*
Inpatient Services					
Hospitalization & Physician Services	0% per visit*	20% per visit*	30% per visit*	$0*	100%*
Maternity Care – High Risk	Not Available	30% per visit*	30% per visit*	Not Available	30%*
Maternity Care – Labor & Delivery	0% per visit*	50% per visit*	50% per visit*	$0*	100%*
Mental Health & Chemical Dependency Treatment Services					
Inpatient	0% per visit*	0% per visit*	30% per visit*	Not Available	20%*
Outpatient	0% per visit*	0% per visit*	30% per visit*	Not Available	20%*
Office Visits	0% per visit*	0% per visit*	30% per visit*	Not Available	$30*
Diabetic Services					
Eye & Foot Exams	0% per visit*	20% per visit*	30% per visit*	$0*	$0*
Additional Services					
Physical Therapy	0% per visit*[2]	20% per visit*	30% per visit*	0%* per visit	20%*
Occupational & Speech Therapy	0% per visit*[2]	20% per visit*	30% per visit*	0%* per visit	20%*
Durable Medical Equipment (DME)	Not available[4]	20% per service/device*	30% per service/device*	Not Available	20%*
Home & Hospice Care	0% per visit*	20% per visit*	30% per visit*	$0*	20%*
Acupuncture (12 Visit Max)	0% per visit*	20% per visit*	20% per visit*	Not Available	$30

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Deductibles, coinsurance and flat dollar copayments (medical and prescription drug) apply to the plan year (calendar) maximum out of pocket expense.

- **A HDHP requires member to pay the full deductible before copay or coinsurance amounts apply.**

[1]If service is not available at SCH

[2]Deductible and coinsurance will not apply when physical therapy or occupational therapy services are provided at Ortho Rhode Island locations. Note physical therapy is the only Tier 1 service at South County Orthopedics. The South County Health Tier 1 Network consists of South County Hospital, South County Home Health, and South County Medical Group.

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