2027 MEDICAL PLAN FAQS

SOUTH COUNTY HEALTH

South County Health's employee health plan is moving its plan administration to United Healthcare/ UMR and UMR/HealthSCOPE Benefits for 2027. The UnitedHealthcare Choice Plus network supports network-based options, while Premier Choice uses a different open-access reimbursement model and dedicated Plan Advisor assistance.

You are encouraged to use South County Health for the care that we provide under all plans.

Important: *These answers summarize the current working plan design. Final benefit documents, provider participation, authorizations and enrollment materials govern. Specific administrative details identified below are still being finalized.*

1. If I see an Ortho RI specialist, can I get imaging or surgery at Ortho RI under the EPO plan?

A specialist office visit at Ortho RI has a $50 copay under the EPO. For laboratory work, imaging, or a procedure that South County Health provides, ask the ordering provider to arrange that service through South County Hospital. Surgery at Ortho RI's ambulatory surgery center will result in substantially higher out-of-pocket costs. The office visit benefit does not mean that all other Ortho RI services are covered at the same cost. Labs and imaging should be done at South County Hospital to avoid out-of-pocket costs. Confirm the facility, service, and authorization requirements before care.

2. What does "little to no out-of-pocket cost at South County Health" mean? Is this different under the EPO and Premier Choice plans?

Under both the EPO and Premier Choice plans, most covered services received through the Tier 1/South County Health provider network have no member cost sharing. A notable exception is the $200 emergency department copay, which is waived if you are admitted. Services obtained outside Tier 1 may involve deductibles, copays, or coinsurance, depending on the plan, provider, and service.

3. Why is the Premier Choice plan less expensive? What is the catch?

Premier Choice is intended to lower employee and SCH costs by encouraging high-quality, cost-effective care and using a different approach to provider reimbursement. Unlike plans that pay negotiated rates through a traditional medical network, Premier Choice uses an open-access approach with assistance from a dedicated Plan Advisor team. You still pay the copay, deductible, or coinsurance specified in your plan. Because not every provider has agreed in advance to the plan's reimbursement, a provider may send a bill for an additional amount (often called balance billing). If this happens, contact Plan Advisor promptly; the team can review the bill and help work with the provider.

4. How will Premier Choice help me compare providers and choose where to receive care?

You do not have to research care options on your own. Before scheduling a nonemergency service, contact the dedicated Plan Advisor team through UMR/HealthSCOPE Benefits. An advisor can help identify care options, review plan benefits, discuss cost and quality, and address questions about a provider's willingness to work with the plan.

PHCS Provider Search - HST-PHCS Provider Search

5. Can I continue seeing my current doctor or use a facility outside South County Health?

Your options depend on the plan and provider. Under the EPO, nonemergency care generally must be received from providers participating in the UnitedHealthcare Choice Plus Network. SCH Tier 1 providers offer the lowest cost sharing. Under Premier Choice, you generally have more freedom to choose providers, but you should work with Plan Advisor before care to understand reimbursement and your responsibility. The High Deductible Health Plan has its own network, deductible, and cost-sharing rules. For services that SCH offers, choosing an SCH provider can reduce your costs; for services not available at SCH, ask for guidance on an appropriate alternative.

6. Where can I search for providers in the UnitedHealthcare Choice Plus network?

Use the UMR UnitedHealthcare Choice Plus provider directory listed below. Search for your specific physician and facility, including the practice location. Before receiving care, contact the office to confirm that it participates in UnitedHealthcare Choice Plus for your plan. UMR is the plan administrator; UnitedHealthcare Choice Plus is the network name to use when asking about participation.

UMR provider directory: UnitedHealthcare Choice Plus Network (English)

7. Do Brown University Health and Yale New Haven Health accept UnitedHealthcare?

Brown University Health hospitals and physicians, and Yale hospitals, facilities and physicians, including Yale Medicine and Northeast Medical Group, currently participate in UnitedHealthcare employer-sponsored commercial networks, including the Choice Plus network used by SCH's network-based options. The widely reported Brown network change affects certain Medicare Advantage plans, not these employer plans. Network status can change; confirm your particular provider, location, and plan before care. Premier Choice follows a different reimbursement approach and has an open network, not United to United Health Choice Plus Network. Contact a Plan Advisor about a specific Yale or Brown provider.

Current UHC contract updates: Yale New Haven Health

8. What if my pediatrician tells me they do not accept UMR?

First, ask whether the pediatrician participates in the UnitedHealthcare Choice Plus network, rather than whether they "take UMR." UMR administers the plan; Choice Plus is the contracted provider network. If the office does not participate, contact UMR to verify its status and look for in-network pediatricians before choosing the EPO or High Deductible Health Plan. Premier Choice provides another option because it is not limited to a conventional contracted medical network, but contact a Plan Advisor first to discuss how that pediatrician would be reimbursed and how any additional bills would be handled.

9. Is SCH's $350/$700 contribution to the Health Savings Account (HSA) an annual contribution?

Yes. South County Health's annual contribution is $350 for eligible individual coverage or $700 for eligible family coverage under the HSA-qualified High Deductible Health Plan. Contributions are deposited quarterly on the first of the month following each quarter: $87.50 for eligible individual coverage or $175 for eligible family coverage. HSA eligibility rules apply.

10. Do copays count toward my deductible?

Generally, no. A copay is a fixed amount you pay for a covered service and typically does not reduce your deductible. Eligible copays generally do count toward the plan's out-of-pocket maximum. A deductible is the amount you pay for certain covered services before the plan begins sharing those costs.

11. What does coinsurance mean?

Coinsurance is the percentage of an eligible covered expense you pay after meeting any applicable deductible. For example, with 30% coinsurance, you pay $30 of a $100 covered allowed charge and the plan pays $70. The example is illustrative; your plan's actual coinsurance, allowed amount, and out-of-pocket protections control.

12. Will an existing BCBSRI prior authorization carry over for care in 2027?

SCH has requested authorization information from BCBSRI, and UMR/HealthSCOPE Benefits is preparing to receive it. The goal is to minimize duplicate authorizations and disruption to ongoing treatment. However, do not assume every existing authorization has transferred automatically. The Premier Choice plan also uses MedWatch for certain authorization reviews. If you have scheduled surgery, active treatment, or an authorization extending into 2027, contact the appropriate plan team before the service to verify the approval is on file.

13. Can I continue to receive prescriptions or infusion treatment at Brown University Health or Newport Hospital?

It depends on the medication, how it is administered, and the plan. Many infusions and other hospital-based medication services are available at SCH at lower member cost, and lower plan cost, even if you continue seeing your current specialist. Retail and specialty prescription coverage is administered through Liviniti; medications administered in a physician's office or hospital may instead be covered under the medical plan and have site-of-care requirements. Before a treatment, contact Liviniti for pharmacy-benefit questions and your medical plan team for infusions or other facility-administered drugs. Do not stop or delay treatment without speaking with your treating clinician and the plan.

14. Do medical and prescription drug costs count toward the same out-of-pocket maximum?

Yes. Under the 2027 plan design described by SCH, eligible member cost sharing for covered medical and pharmacy benefits accumulates toward the same applicable plan out-of-pocket maximum. Premiums, noncovered services, and any provider amounts that the plan does not recognize as eligible cost sharing do not count.

15. Will the Flexible Spending Accounts (FSAs) continue, and what are the 2027 limits?

SCH continues to offer FSAs. For 2027, the Health Care FSA employee election maximum is $3,500, and the Dependent Care FSA maximum is $5,000. Confirm final election details in SCH's enrollment materials.

16. Is the working-spouse contribution changing for 2027?

No. The working-spouse contribution remains unchanged for 2027.

17. What are the limits on in vitro fertilization (IVF) coverage?

The plan covers up to three in vitro fertilization (IVF) cycles per plan year, with a lifetime maximum of eight IVF cycles per member up to lifetime dollar limits. Infertility services may be provided on an inpatient or outpatient basis, including in a physician's office. Consult the final plan materials for coverage criteria, covered medications, and any prior authorization requirements.

18. My spouse's employer ends open enrollment in mid-November, before SCH's enrollment deadline. Can we wait until the end of SCH's enrollment to decide?

You may make your SCH election by SCH's published enrollment deadline, but you should not assume your spouse can enroll or change a selection after their employer's deadline. SCH's open enrollment is not automatically a qualifying event that extends a different employer's open enrollment. Federal cafeteria-plan rules may permit coordinated prospective election changes when another employer's coverage changes, but each employer's written plan rules must allow the change. Have your spouse ask their benefits team before their deadline what elections or later changes are permitted, and coordinate the 2027 effective dates to prevent a gap in coverage.

19. Can a newly hired employee receive the wellness incentive contribution rate?

No. SCH closed the wellness incentive rate to new entrants effective January 1, 2026. This includes new staff and existing staff who were not already participating.

20. Will physical therapy at Elite still have no out-of-pocket cost?

Elite's care was previously paid in full by SCH; it was not free to the plan. For 2027, Elite is no longer in SCH's Tier 1 network. Continuing in 2027, physical and occupational therapy at Ortho RI will be available at $0 member cost share under all three medical plans, subject to a 20-visit annual limit. Care at Elite will follow the applicable plan's network and cost-sharing rules, and EPO coverage may be unavailable if the provider is out of network. Confirm the therapy location, network participation, and how the visit limit is counted before scheduling.

21. Are my children and other household members eligible for the Employee Assistance Program (EAP) counseling benefit?

Yes, the EAP is available to employees, including per diem staff, and members of their households. The program includes six counseling visits per concern as described in SCH's EAP materials. Contact the EAP provider for additional referral or eligibility details. EAP counseling is separate from benefits for ongoing mental health treatment under the medical plan. Contact SupportLinc at mysupportlinc.com - group code: SouthCountyHealth (no spaces) or call 1-888-881-5462.

22. What happens if I have a medical emergency while on vacation?

Under the Affordable Care Act (ACA), emergency services—such as an emergency room visit or ambulance transport—are covered by your health plan even if you are out-of-state or out-of-network, without needing prior authorization. This pertains to US travel only. However, non-emergency routine or follow-up care outside your plan's network or local service area may not be covered.

23. Are preventative health services covered if obtained by a Tier 2 provider?

Generally, these services are covered at no cost to you when provided by an in-network medical provider. In most cases, you won't pay a copayment or coinsurance for certain preventive services like immunizations and screening tests, even if you haven't met your deductible. Click the link for the preventative services for adults, women and children.

HealthCare.gov - https://www.healthcare.gov/coverage/preventive-care-benefits/