



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, please visit [www.nhpri.org](http://www.nhpri.org) or by calling 1-855-321-9244. 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 <https://www.healthcare.gov/sbc-glossary> or call 1-855-321-9244 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                  | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$4,750 Individual/<br>\$9,500 Family                                                                                                                    | If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                                                                                                                                               |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. Doesn't apply to medical and behavioral health services with a fixed copayment, preventative services and prescription drugs in tier 1, 2, & 3.     | For example, this plan covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>                                                                                                                                                                                                                                                                               |
| Are there other <a href="#">deductibles</a> for specific services?              | No                                                                                                                                                       | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$8,700 Individual/<br>\$17,400 Family                                                                                                                   | If you have other family members in this plan, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                                                                                               |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Premiums, balance-billing charges, and health care this plan doesn't cover                                                                               | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket</a> limit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://www.nhpri.org/find-a-doctor/">https://www.nhpri.org/find-a-doctor/</a> or call 1-855-321-9244 for a list of network providers. | This plan uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your plan pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No                                                                                                                                                       | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

 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<br>(You will pay the least)    | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                           |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>                                                                                                                     | Primary care visit to treat an injury or illness       | \$35 copay/office visit                         | Not Covered                                        | \$0 copay for the first two non-preventative visits per plan year.                                                                                        |
|                                                                                                                                                                                                   | <a href="#">Specialist</a> visit                       | \$75 copay/visit                                | Not Covered                                        | <a href="#">Preauthorization</a> may be required. Acupuncture and chiropractic care is limited to 12 visits a year.                                       |
|                                                                                                                                                                                                   | <a href="#">Preventive care/screening/immunization</a> | No Charge                                       | Not Covered                                        | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| <b>If you have a test</b>                                                                                                                                                                         | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 40% coinsurance                                 | Not Covered                                        | No charge for preventive laboratory tests associated with <a href="#">preventive visit</a>                                                                |
|                                                                                                                                                                                                   | Imaging (CT/PET scans, MRIs)                           | 40% coinsurance                                 | Not Covered                                        | Preauthorization may be required                                                                                                                          |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.nhpri.org">www.nhpri.org</a> | Affordable Care Act Preventative Drugs                 | \$0 copay/prescription                          | Not Covered                                        | For up to a 30-day supply                                                                                                                                 |
|                                                                                                                                                                                                   | Adherence Generic Drugs                                | \$5 copay/prescription                          | Not Covered                                        | For up to a 30-day supply                                                                                                                                 |
|                                                                                                                                                                                                   | Other Generic Drugs                                    | \$15 copay/prescription                         | Not Covered                                        | For up to a 30-day supply                                                                                                                                 |
|                                                                                                                                                                                                   | Preferred Brands                                       | \$50 copay/prescription                         | Not Covered                                        | For up to a 30-day supply                                                                                                                                 |
|                                                                                                                                                                                                   | Non-Preferred Brands                                   | \$75 after deductible                           | Not Covered                                        | For up to a 30-day supply                                                                                                                                 |
|                                                                                                                                                                                                   | Preferred Specialty Drugs                              | 50% coinsurance, up to \$150 copay/prescription | Not Covered                                        | For up to a 30-day supply                                                                                                                                 |
|                                                                                                                                                                                                   | Non-Preferred Specialty Drugs                          | 50% coinsurance, up to \$150 copay/prescription | Not Covered                                        | For up to a 30-day supply                                                                                                                                 |
| <b>If you have outpatient surgery</b>                                                                                                                                                             | Facility fee (e.g., ambulatory surgery center)         | 40% coinsurance                                 | Not Covered                                        | Preauthorization may be required                                                                                                                          |
|                                                                                                                                                                                                   | Physician/surgeon fees                                 | 40% coinsurance                                 | Not Covered                                        | Preauthorization may be required                                                                                                                          |
| <b>If you need immediate</b>                                                                                                                                                                      | <a href="#">Emergency room care</a>                    | 40% coinsurance                                 | 40% coinsurance                                    | None                                                                                                                                                      |

| Common Medical Event                                                             | Services You May Need                            | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                          |
|----------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------|
|                                                                                  |                                                  | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                 |
| <b>medical attention</b>                                                         | <a href="#">Emergency medical transportation</a> | 40% coinsurance; \$50 max per trip           | 40% coinsurance \$50 max per trip                  | None                                                                            |
|                                                                                  | <a href="#">Urgent care</a>                      | \$75 copay/visit                             | \$75 copay/visit                                   | None                                                                            |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)               | 40% coinsurance                              | Not Covered                                        | Preauthorization may be required                                                |
|                                                                                  | Physician/surgeon fees                           | 40% coinsurance                              | Not Covered                                        | Preauthorization may be required                                                |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services (Office)                     | \$35 copay/office visit                      | Not Covered                                        | \$0 copay for the first two visits per plan year.                               |
|                                                                                  | Outpatient services (Other)                      | 40% coinsurance                              | Not Covered                                        | None                                                                            |
|                                                                                  | Inpatient services                               | 40% coinsurance                              | Not Covered                                        | None                                                                            |
| <b>If you are pregnant</b>                                                       | Office visits                                    | \$75 copay/visit                             | Not Covered                                        | Cost sharing does not apply for preventative services                           |
|                                                                                  | Childbirth/delivery professional services        | 40% coinsurance                              | Not Covered                                        | None                                                                            |
|                                                                                  | Childbirth/delivery facility services            | 40% coinsurance                              | Not Covered                                        | None                                                                            |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>                 | 40% coinsurance                              | Not Covered                                        | Preauthorization may be required                                                |
|                                                                                  | <a href="#">Rehabilitation services</a>          | \$75 copay/visit                             | Not Covered                                        | Preauthorization may be required                                                |
|                                                                                  | <a href="#">Habilitation services</a>            | \$75 copay/visit                             | Not Covered                                        | Preauthorization may be required                                                |
|                                                                                  | <a href="#">Skilled nursing care</a>             | 40% coinsurance                              | Not Covered                                        | Preauthorization may be required                                                |
|                                                                                  | <a href="#">Durable medical equipment</a>        | 40% coinsurance                              | Not Covered                                        | Preauthorization may be required                                                |
|                                                                                  | <a href="#">Hospice services</a>                 | 40% coinsurance                              | Not Covered                                        | Preauthorization may be required                                                |
| <b>If your child needs dental or eye care</b>                                    | Children's eye exam                              | \$75 copay/visit                             | Not Covered                                        | Limit of once per year                                                          |
|                                                                                  | Children's glasses                               | 40% coinsurance                              | Not Covered                                        | Limit of one pair of frames and lenses, or one pair of contact lenses, per year |

| Common Medical Event | Services You May Need      | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information |
|----------------------|----------------------------|----------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
|                      |                            | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                        |
|                      | Children's dental check-up | No Charge                                    | 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 (adult)
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- 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
- Bariatric surgery
- Chiropractic care
- Doula Services
- Hearing aids
- Infertility treatment
- Private-duty nursing
- Routine eye care (Adult)
- Coverage provided outside the United States. See [www.nhpri.org](http://www.nhpri.org)
- Abortion

**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: Healthsource RI [www.healthsourceri.com](http://www.healthsourceri.com) or you can call 1-855-840-4774.

**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 on how 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 your state insurance department at 1-855-747-3224 or by email at [HealthInquiry@ohic.ri.gov](mailto:HealthInquiry@ohic.ri.gov), the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

**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 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 **1-855-321-9244**.

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-855-321-9244**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-855-321-9244**.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1-855-321-9244**.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwiijigo holne' **1-855-321-9244**.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4750 |
| ■ <a href="#">Specialist</a> copayment                          | \$75   |
| ■ Hospital (facility) coinsurance                               | 40%    |
| ■ Other coinsurance                                             | 40%    |

#### 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> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$4,750        |
| Copayments                        | \$10           |
| Coinsurance                       | \$3,100        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$7,920</b> |

### Managing Joe's type 2 Diabetes

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

|                                                                 |        |
|-----------------------------------------------------------------|--------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4750 |
| ■ <a href="#">Specialist</a> copayment                          | \$75   |
| ■ Hospital (facility) coinsurance                               | 40%    |
| ■ Other coinsurance                                             | 40%    |

#### 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> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$900          |
| Copayments                        | \$1,000        |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,920</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |        |
|-----------------------------------------------------------------|--------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4750 |
| ■ <a href="#">Specialist</a> copayment                          | \$75   |
| ■ Hospital (facility) coinsurance                               | 40%    |
| ■ Other coinsurance                                             | 40%    |

#### 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> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,100        |
| Copayments                        | \$600          |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,700</b> |