**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 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 deductible?** | **$850** Individual/ **$1,700** Family | 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.** Doesn't apply to medical and behavioral health services with a fixed copayment (excluding ER), preventative services and prescription drugs. | 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 don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **$2,950** Individual/ **$5,900** Family | 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-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 https://www.nhpri.org/find-a-doctor/ or call 1**-855-321-9244** 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 can see the specialist you choose without a referral. |

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 | $20 copay/office visit | Not Covered | $0 copay for the first two non-preventative visits per plan year. |
| | Specialist visit | $40 copay/visit | Not Covered | Preauthorization may be required. Acupuncture and chiropractic care is limited to 12 visits a year. |
| | Preventive care/screening/ Immunization | 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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 0% coinsurance | Not Covered | No charge for preventive laboratory tests associated with preventive visit |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance | Not Covered | Preauthorization may be required |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.nhpri.org | 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 | $10 copay/prescription | Not Covered | For up to a 30-day supply |
| | Preferred Brands | $35 copay/prescription | Not Covered | For up to a 30-day supply |
| | Non-Preferred Brands | $55 copay/prescription | 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 |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance | Not Covered | Preauthorization may be required |
| | Physician/surgeon fees | 0% coinsurance | Not Covered | Preauthorization may be required |
| **If you need immediate** | Emergency room care | $250 copay/visit | $250 copay/visit | 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) | |
| **medical attention** | Emergency medical transportation | 0% coinsurance; $50 max per trip | 0% coinsurance $50 max per trip | None |
| | Urgent care | $40 copay/visit | $40 copay/visit | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% coinsurance | Not Covered | Preauthorization may be required |
| | Physician/surgeon fees | 0% coinsurance | Not Covered | Preauthorization may be required |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services (Office) | $20 copay/office visit | Not Covered | $0 copay for the first two visits per plan year. |
| | Outpatient services (Other) | 0% coinsurance | Not Covered | None |
| | Inpatient services | 0% coinsurance | Not Covered | None |
| **If you are pregnant** | Office visits | $40 copay/visit | Not Covered | Cost sharing does not apply for preventative services |
| | Childbirth/delivery professional services | 0% coinsurance | Not Covered | None |
| | Childbirth/delivery facility services | 0% coinsurance | Not Covered | None |
| **If you need help recovering or have other special health needs** | Home health care | 0% coinsurance | Not Covered | Preauthorization may be required |
| | Rehabilitation services | $40 copay/visit | Not Covered | Preauthorization may be required |
| | Habilitation services | $40 copay/visit | Not Covered | Preauthorization may be required |
| | Skilled nursing care | 0% coinsurance | Not Covered | Preauthorization may be required |
| | Durable medical equipment | 0% coinsurance | Not Covered | Preauthorization may be required |
| | Hospice services | 0% coinsurance | Not Covered | Preauthorization may be required |
| **If your child needs dental or eye care** | Children's eye exam | $40 copay/visit | Not Covered | Limit of once per year |
| | Children's glasses | No Charge | 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 (You will pay the least) | Out-of-Network Provider (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.)**

- Abortion
- 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

**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 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 HealthInsInquiry@ohic.ri.gov, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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.

**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): Dinek'ehgo 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 plan's overall deductible** | **$850** |
| **Specialist copayment** | **$40** |
| **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 | $850 |
| Copayments | $10 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$920** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$850** |
| **Specialist copayment** | **$40** |
| **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** | **$5,600** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $850 |
| Copayments | $900 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,770** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$850** |
| **Specialist copayment** | **$40** |
| **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** | **$2,800** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $850 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,250** |

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