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

<table>
<thead>
<tr>
<th>What is the overall deductible?</th>
<th>$1,000 Individual/ $2,000 Family</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care, primary care, specialist visit, urgent care, emergency room care, prescription drugs in tier 1, 2, 3, &amp; 4, and outpatient services for mental health, behavioral health, and substance use</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$5,900 Individual/ $11,800 Family</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, and health care this plan doesn’t cover</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="https://www.nhpri.org/BecomeMember/FindaDoctor.aspx">https://www.nhpri.org/BecomeMember/FindaDoctor.aspx</a> or call 1-855-321-9244 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least) $20 copay/office visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>Preauthorization may be required. Acupuncture and chiropractic care is limited to 12 visits a year.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>No charge for laboratory tests if performed within 2 weeks of an associated preventive visit</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>Preauthorization may be required</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Low Cost Maintenance Generics</td>
<td>$5 copay/prescription</td>
<td>For up to a 30-day supply</td>
</tr>
<tr>
<td>More information about <strong>prescription drug coverage</strong> is available at <a href="http://www.nhpri.org">www.nhpri.org</a></td>
<td>Other Generics</td>
<td>$10 copay/prescription</td>
<td>For up to a 30-day supply</td>
</tr>
<tr>
<td></td>
<td>Preferred Brands Maintenance</td>
<td>$35 copay/prescription</td>
<td>For up to a 30-day supply</td>
</tr>
<tr>
<td></td>
<td>Brands</td>
<td>$50 copay/prescription</td>
<td>For up to a 30-day supply</td>
</tr>
<tr>
<td></td>
<td>High Cost and Specialty</td>
<td>30% coinsurance</td>
<td>For up to a 30-day supply</td>
</tr>
<tr>
<td></td>
<td>Covered Non Preferred</td>
<td>30% coinsurance</td>
<td>For up to a 30-day supply</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>Preauthorization may be required</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>Preauthorization may be required</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$200 copay/visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical</td>
<td>20% coinsurance; $50 max</td>
<td>None</td>
</tr>
</tbody>
</table>

For more information about limitations and exceptions, see the plan or policy document at [www.nhpri.org](http://www.nhpri.org)
<table>
<thead>
<tr>
<th>Common Medical Event</th>
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<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Per trip</td>
<td>Trip</td>
</tr>
<tr>
<td>transportation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td></td>
<td>$40 copay/visit</td>
<td>$40 copay/visit</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$20 copay/office visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$40 copay/visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$40 copay/visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>$40 copay/visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>0% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

For more information about limitations and exceptions, see the plan or policy document at [www.nhpri.org](http://www.nhpri.org)
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Dental care (adult)</td>
</tr>
<tr>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside of the U.S.</td>
</tr>
<tr>
<td>• Routine foot care</td>
</tr>
<tr>
<td>• Weight loss programs</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Abortion</th>
<th>Hearing aids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>Infertility treatment</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td>Private-duty nursing</td>
</tr>
<tr>
<td>Chiropractic care</td>
<td>Routine eye care (Adult)</td>
</tr>
<tr>
<td>Coverage provided outside the United States. See <a href="http://www.nhpr1.org">www.nhpr1.org</a></td>
<td></td>
</tr>
</tbody>
</table>

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: HealthsouceRI 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 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
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:
Navajo (Dine): Dinek’ehgo shika a’ohwol ninisingo, kwiiijigo holne’ 1-855-321-9244.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

For more information about limitations and exceptions, see the plan or policy document at www.nhpr1.org
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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
</tbody>
</table>

- **The plan’s overall deductible**: $1000
- **Specialist copayment**: $40
- **Hospital (facility) coinsurance**: 20%
- **Other coinsurance**: 20%

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**: $12,731

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$44</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,631</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0

**The total Peg would pay is**: $2,675

- **The plan’s overall deductible**: $1000
- **Specialist copayment**: $40
- **Hospital (facility) coinsurance**: 20%
- **Other coinsurance**: 20%

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**: $7,389

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,050</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$172</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0

**The total Joe would pay is**: $2,222

- **The plan’s overall deductible**: $1000
- **Specialist copayment**: $40
- **Hospital (facility) coinsurance**: 20%
- **Other coinsurance**: 20%

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**: $1,925

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$266</td>
</tr>
<tr>
<td>Copayments</td>
<td>$530</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0

**The total Mia would pay is**: $796

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