
 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 ? | \$0 Individual/ \$0 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. Preventive Care | 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 ? | \$2,250 Individual/ \$4,500 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 | 10% coinsurance | Not Covered | None |
| | Specialist visit | 10% coinsurance | 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) | 10% coinsurance | Not Covered | No charge for preventive laboratory tests associated with preventive visit |
| | Imaging (CT/PET scans, MRIs) | 10% 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 | Low Cost Maintenance Generics | \$2 copay/prescription | Not Covered | For up to a 30-day supply |
| | Other Generics | \$5 copay/prescription | Not Covered | For up to a 30-day supply |
| | Preferred Brands Maintenance | \$15 copay/prescription | Not Covered | For up to a 30-day supply |
| | Brands | \$30 copay/prescription | Not Covered | For up to a 30-day supply |
| | High Cost and Specialty | 10% coinsurance | Not Covered | For up to a 30-day supply |
| | Covered Non Preferred | 10% coinsurance | Not Covered | For up to a 30-day supply |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | Not Covered | Preauthorization may be required |
| | Physician/surgeon fees | 10% coinsurance | Not Covered | Preauthorization may be required |
| If you need immediate medical attention | Emergency room care | 10% coinsurance | 10% coinsurance | None |
| | Emergency medical transportation | 10% coinsurance; \$50 max per trip | 10% coinsurance \$50 max per trip | 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) | |
| | Urgent care | 10% coinsurance | 10% coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance | Not Covered | Preauthorization may be required |
| | Physician/surgeon fees | 10% coinsurance | Not Covered | Preauthorization may be required |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 10% coinsurance | Not Covered | Preauthorization may be required |
| | Inpatient services | 10% coinsurance | Not Covered | Preauthorization may be required |
| If you are pregnant | Office visits | 10% coinsurance | Not Covered | Cost sharing does not apply for preventative services |
| | Childbirth/delivery professional services | 10% coinsurance | Not Covered | None |
| | Childbirth/delivery facility services | 10% coinsurance | Not Covered | None |
| If you need help recovering or have other special health needs | Home health care | 10% coinsurance | Not Covered | Preauthorization may be required |
| | Rehabilitation services | 10% coinsurance | Not Covered | Preauthorization may be required |
| | Habilitation services | 10% coinsurance | Not Covered | Preauthorization may be required |
| | Skilled nursing care | 10% coinsurance | Not Covered | Preauthorization may be required |
| | Durable medical equipment | 10% coinsurance | Not Covered | Preauthorization may be required |
| | Hospice services | 10% coinsurance | Not Covered | Preauthorization may be required |
| If your child needs dental or eye care | Children's eye exam | 10% coinsurance | Not Covered | Limit of once per year |
| | Children's glasses | 10% coinsurance | Not Covered | Limit of one pair of frames and lenses, or one pair of contact lenses, per year |
| | 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

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: HealthsourceRI www.healthsourceri.com or you can call 1-855-840-4774.

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
- Hearing aids
- Infertility treatment
- Private-duty nursing
- Routine eye care (Adult)
- Coverage provided outside the United States. See www.nhpri.org

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:

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, kwijigo 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](#) \$0
- [Specialist](#) coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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 | \$12,671 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$20 |
| Coinsurance | \$1,260 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$1,280 |

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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 | \$7,334 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$545 |
| Coinsurance | \$293 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$838 |

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$150 |
| Coinsurance | \$117 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$267 |