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?	**$775** Individual/ **$1,550** 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?	**$3,000** Individual/ **$6,000** 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	Adherence Generic Drugs	$5 copay/prescription	Not Covered	For up to a 30-day supply
	Other Generic Drugs	$7 copay/prescription	Not Covered	For up to a 30-day supply
	Preferred Brands	$30 copay/prescription	Not Covered	For up to a 30-day supply
	Non-Preferred Brands	$45 copay/prescription	Not Covered	For up to a 30-day supply
	Preferred Specialty Drugs	10% coinsurance	Not Covered	For up to a 30-day supply
	Non-Preferred Specialty Drugs	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	None
	Habilitation services	10% coinsurance	Not Covered	None
	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

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 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	$775
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	**$12,640**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$775
Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,985**

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

The plan's overall deductible	$775
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	**$5,580**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$775
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,475**

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

The plan's overall deductible	$775
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$775
Copayments	$100
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$975**

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