
 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 ? | \$2,950 Individual/ \$5,900 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 ? | \$8,500 Individual/ \$17,000 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 | 15% coinsurance | Not Covered | None |
| | Specialist visit | 15% 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) | 15% coinsurance | Not Covered | No charge for preventive laboratory tests associated with preventive visit |
| | Imaging (CT/PET scans, MRIs) | 15% 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 | \$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 | \$50 copay/prescription | Not Covered | For up to a 30-day supply |
| | Preferred Specialty Drugs | 50% coinsurance | Not Covered | For up to a 30-day supply |
| | Non-Preferred Specialty Drugs | 50% coinsurance | Not Covered | For up to a 30-day supply |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 15% coinsurance | Not Covered | Preauthorization may be required |
| | Physician/surgeon fees | 15% coinsurance | Not Covered | Preauthorization may be required |
| If you need immediate medical attention | Emergency room care | 15% coinsurance | 15% coinsurance | None |
| | Emergency medical transportation | 15% coinsurance; \$50 max per trip | 15% 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 | 15% coinsurance | 15% coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 15% coinsurance | Not Covered | Preauthorization may be required |
| | Physician/surgeon fees | 15% coinsurance | Not Covered | Preauthorization may be required |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 15% coinsurance | Not Covered | Preauthorization may be required |
| | Inpatient services | 15% coinsurance | Not Covered | Preauthorization may be required |
| If you are pregnant | Office visits | 15% coinsurance | Not Covered | Cost sharing does not apply for preventative services |
| | Childbirth/delivery professional services | 15% coinsurance | Not Covered | None |
| | Childbirth/delivery facility services | 15% coinsurance | Not Covered | None |
| If you need help recovering or have other special health needs | Home health care | 15% coinsurance | Not Covered | Preauthorization may be required |
| | Rehabilitation services | 15% coinsurance | Not Covered | None |
| | Habilitation services | 15% coinsurance | Not Covered | None |
| | Skilled nursing care | 15% coinsurance | Not Covered | Preauthorization may be required |
| | Durable medical equipment | 15% coinsurance | Not Covered | Preauthorization may be required |
| | Hospice services | 15% coinsurance | Not Covered | Preauthorization may be required |
| If your child needs dental or eye care | Children's eye exam | 15% coinsurance | Not Covered | Limit of once per year |
| | Children's glasses | 15% 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 .) | | |
|---|--|---|
| <ul style="list-style-type: none">• Cosmetic surgery• Dental care (adult) | <ul style="list-style-type: none">• Long-term care• Non-emergency care when traveling outside of the U.S. | <ul style="list-style-type: none">• 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.) | | |
| <ul style="list-style-type: none">• Abortion• Acupuncture• Bariatric surgery• Chiropractic care | <ul style="list-style-type: none">• Hearing aids• Infertility treatment• Private-duty nursing• Routine eye care (Adult) | <ul style="list-style-type: none">• 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 HealthInquiry@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, 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](#) \$2950
- [Specialist](#) coinsurance 15%
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2,950 |
| Copayments | \$10 |
| Coinsurance | \$1,400 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$4,360 |

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

- The [plan's](#) overall [deductible](#) \$2950
- [Specialist](#) coinsurance 15%
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2,300 |
| Copayments | \$500 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$2,800 |

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

- The [plan's](#) overall [deductible](#) \$2950
- [Specialist](#) coinsurance 15%
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,900 |
| Copayments | \$100 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,000 |