
 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](http://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 <a href="#">deductible</a> ?	<b>\$1,200</b> Individual/ <b>\$2,400</b> Family	If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	<b>Yes.</b> Preventive care, primary care, specialist visit, urgent care, prescription drugs in tier 1, 2, 3, & 4, and outpatient services for mental health, behavioral health, and substance use	For example, this plan covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> 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>
Are there other <a href="#">deductibles</a> for specific services?	<b>No</b>	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$3,000</b> Individual/ <b>\$6,000</b> Family	If you have other family members in this plan, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billing charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket</a> limit.
Will you pay less if you use a <a href="#">network provider</a> ?	<b>Yes.</b> See <a href="https://www.nhpri.org/find-a-doctor/">https://www.nhpri.org/find-a-doctor/</a> or call 1-855-321-9244 for a list of network providers.	This plan uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your plan pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	<b>No</b>	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$10 copay/office visit	Not Covered	None
	<a href="#">Specialist</a> visit	\$20 copay/visit	Not Covered	<a href="#">Preauthorization</a> may be required. Acupuncture and chiropractic care is limited to 12 visits a year.
	<a href="#">Preventive care/screening/immunization</a>	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% coinsurance	Not Covered	No charge for preventive laboratory tests associated with <a href="#">preventive visit</a>
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not Covered	Preauthorization may be required
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.nhpri.org">www.nhpri.org</a>	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	\$50 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
<b>If you have outpatient surgery</b>	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
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	10% coinsurance	10% coinsurance	None
	<a href="#">Emergency medical</a>	10% coinsurance; \$50 max	10% coinsurance \$50 max per	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)	
	<a href="#">transportation</a>	per trip	trip	
	<a href="#">Urgent care</a>	\$20 copay/visit	\$20 copay/visit	None
<b>If you have a hospital stay</b>	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
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$10 copay/office visit	Not Covered	Preauthorization may be required
	Inpatient services	10% coinsurance	Not Covered	Preauthorization may be required
<b>If you are pregnant</b>	Office visits	\$20 copay/visit	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
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% coinsurance	Not Covered	Preauthorization may be required
	<a href="#">Rehabilitation services</a>	\$20 copay/visit	Not Covered	None
	<a href="#">Habilitation services</a>	\$20 copay/visit	Not Covered	None
	<a href="#">Skilled nursing care</a>	10% coinsurance	Not Covered	Preauthorization may be required
	<a href="#">Durable medical equipment</a>	10% coinsurance	Not Covered	Preauthorization may be required
	<a href="#">Hospice services</a>	10% coinsurance	Not Covered	Preauthorization may be required
<b>If your child needs dental or eye care</b>	Children's eye exam	\$20 copay/visit	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](#).)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- 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.)

- 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](http://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](http://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](mailto:HealthInquiry@ohic.ri.gov), the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://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](#) \$1200
- [Specialist](#) copayment \$20
- 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*)

<b>Total Example Cost</b>	<b>\$12,640</b>
---------------------------	-----------------

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

<i>Cost Sharing</i>	
Deductibles	\$1,200
Copayments	\$10
Coinsurance	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,310</b>

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

- The [plan's](#) overall [deductible](#) \$1200
- [Specialist](#) copayment \$20
- 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*)

<b>Total Example Cost</b>	<b>\$5,580</b>
---------------------------	----------------

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

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,700</b>

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

- The [plan's](#) overall [deductible](#) \$1200
- [Specialist](#) copayment \$20
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

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

<i>Cost Sharing</i>	
Deductibles	\$1,100
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,300</b>