The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>www.nhpri.org</u> or by calling 1-855-321-9244. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> 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?	\$6,000 Individual/ \$12,000 Family	If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Preventive care	For example, this plan covers certain <u>preventive services</u> without <u>cost sharing</u> 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 <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$6,550 Individual/ \$13,100 Family	If you have other family members in this plan, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	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 <u>network provider</u> ?	Yes. See https://www.nhpri.org/Becomea Member/FindaDoctor.aspx or call 1-855-321-9244 for a list of network providers.	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your plan pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Wh		What Y	ou Will Pay	Limitations, Exceptions, & Other
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	Not Covered	None
	Specialist visit	0% 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)	0% coinsurance	Not Covered	No charge for laboratory tests if performed within 2 weeks of an associated preventive visit
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not Covered	Preauthorization may be required
	Low Cost Maintenance Generics	\$5 copay/prescription	Not Covered	For up to a 30-day supply
If you need drugs to treat your illness or	Other Generics	\$10 copay/prescription	Not Covered	For up to a 30-day supply
condition More information about	Preferred Brands Maintenance	\$35 copay/prescription	Not Covered	For up to a 30-day supply
prescription drug coverage is available at	Brands	\$50 copay/prescription	Not Covered	For up to a 30-day supply
www.nhpri.org	High Cost and Specialty	30% coinsurance	Not Covered	For up to a 30-day supply
	Covered Non Preferred	30% coinsurance	Not Covered	For up to a 30-day supply
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not Covered	Preauthorization may be required
surgery	Physician/surgeon fees	0% coinsurance	Not Covered	Preauthorization may be required
If you need immediate	Emergency room care	0% coinsurance	0% coinsurance	None
medical attention	Emergency medical transportation	0% coinsurance; \$50 max per trip	0% coinsurance \$50 max per trip	None

Common Medical Event	Services You May Need	What You Network Provider (You will pay the least)	ou Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	<u>Urgent care</u>	0% coinsurance	0% coinsurance	None
If you have a hospital	Facility fee (e.g., hospital room)	0% coinsurance	Not Covered	Preauthorization may be required
stay	Physician/surgeon fees	0% coinsurance	Not Covered	Preauthorization may be required
If you need mental health, behavioral	Outpatient services	0% coinsurance	Not Covered	Preauthorization may be required
health, or substance abuse services	Inpatient services	0% coinsurance	Not Covered	Preauthorization may be required
	Office visits	No Charge	Not Covered	Cost sharing does not apply for preventative services
If you are pregnant	Childbirth/delivery professional services	0% coinsurance	Not Covered	None
	Childbirth/delivery facility services	0% coinsurance	Not Covered	None
	Home health care	0% coinsurance	Not Covered	Preauthorization may be required
	Rehabilitation services	0% coinsurance	Not Covered	Preauthorization may be required
If you need help recovering or have	Habilitation services	0% coinsurance	Not Covered	Preauthorization may be required
other special health needs	Skilled nursing care	0% coinsurance	urance Not Covered	Preauthorization may be required
	Durable medical equipment	0% coinsurance	Not Covered	Preauthorization may be required
	Hospice services	0% coinsurance	Not Covered	Preauthorization may be required
	Children's eye exam	0% coinsurance	Not Covered	Limit of once per year
If your child needs dental or eye care	Children's glasses	0% 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

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:

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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$6000
■ Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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)

In this example, Peg would pay:

Cost Sharing			
Deductibles	\$6,000		
Copayments	\$44		
Coinsurance	\$0		
What isn't covered			
Limits or exclusions	\$0		
The total Peg would pay is	\$6,044		

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$6000
■ Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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:

\$6,000
\$139
\$0
\$0
\$6,139

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$6000 0%
■ Specialist coinsurance	
Hospital (facility) coinsurance	0%
Other coincurance	0%

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:

Cost Sharing		
Deductibles	\$1,382	
Copayments	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$1,382	