# 2016





- Easily compare plans from the state's top carriers, all in one place
- Nearly 9 out of 10 HealthSource RI customers received financial help this year. Use our Savings Calculator at HealthSourceRI.com/calculator to see if you qualify
- Visit HealthSourceRl.com to enroll or call 1-855-840-4774 for assistance



**INDIVIDUAL MARKET PLANS & BENEFITS** 

# **Monthly Tax Credits:**

Some Rhode Islanders are eligible for tax credits that may reduce the cost of their monthly premium. These credits are based on income and family size. The tables show examples of family sizes and income levels and their eligibility for tax credits.

Single Adults:						
Age	Tax Credits by Annual Income					
	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	
21 year old	\$122	\$62	\$0	\$0	\$0	
40 year old	\$179	\$119	\$54	\$0	\$0	
60 year old	\$473	\$414	\$348	\$277	\$234	

Families:							
Families of 2	Tax Cre	dits by Annua	l Household	Income			
Adults (40 years)	Children (0-18 years)	\$30,000	\$40,000	\$50,000	\$60,000		
1	1	\$115	\$0	\$0	\$0		
2	0	\$377	\$250	\$121	\$41		
Families of 3	Families of 3		Tax Credits by Annual Household Income				
Adults (40 years)	Children (0-18 years)	\$30,000	\$45,000	\$60,000	\$75,000		
1	2	\$161	\$0	\$41	\$0		
2	1	\$423	\$252	\$173	\$50		
Families of 4	Tax Cre	dits by Annua	al Household	Income			
Adults (40 years)	Children (0-18 years)	\$45,000	\$60,000	\$75,000	\$90,000		
1	3	\$47	\$0	\$49	\$0		
2	2	\$309	\$119	\$180	\$60		



#### When to Enroll or Renew:

Open enrollment runs November 1, 2015 through January 31, 2016.

#### Important dates for picking your 2016 health insurance:

**November 1** First day to shop for coverage

**December 23** Deadline to choose a plan for January 2016

**December 23** Deadline to pay and ensure coverage is

processed by January 1

**December 31** Very last day to pay for January coverage

(ID cards will be delayed)

January 31 Last day to shop for or make a change to

your 2016 coverage

#### How to Enroll or Renew:

Online - Visit HealthSourceRl.com to:

- Enroll or renew coverage
- Compare plans and costs through our savings calculator
- Find in-person enrollment help through a Navigator in your community
- Look for our calendar of enrollment events throughout the state

**By phone -** Call 1-855-840-4774 M - F 8 am-7 pm,

You can also call 2-1-1 to find in-person enrollment assistance through a Navigator in your community.

Walk-in - 401 Wampanoag Trail, East Providence 02915

#### Notes:

Preferred Provider Organization (PPO): You will pay less if you use hospitals and doctors in the plan's preferred network, but you are often free to see providers who are not in the preferred network.

Health Maintenance Organization (HMO) / Point of Service (POS): You agree to use only providers who are part of the network. In some plans, you must choose a Primary Care provider, who coordinates your care.

- \* This plan does not cover abortion except in very limited circumstances (check your policy or plan document for further information). No portion of the premium paid for this plan is placed in an allocation account, established for the coverage of elective abortion services, and defined by 45 CFR section 156(e)(3).
- \*\* Cost Sharing Reduction (CSR) plans are Silver plans that have reduced deductibles, coinsurance, and copayments. You may qualify for CSR plans if you earn less than \$29,175 for an individual or \$59,625 for a family of four.
- <sup>1</sup> Per Occurrence Copayment: The amount that you must pay, (prior to and in addition to any Annual Deductible) before UnitedHealthcare will begin paying for Benefits for those Covered Health Services.

Child/children likely eligible for free coverage RIteCare

<sup>&</sup>lt;sup>2</sup> A modified variation of this plan that excludes coverage for most abortions is also available. "Modified" in the plan name indicates the modified variation.

Nearly 9 out of 10 HealthSource RI customers received financial help this year. Use our Savings Calculator at HealthSourceRI.com/calculator to see if you qualify.



Plan   Name		Insurance Company	BCBSRI	BCBSRI	BCBSRI	NHPRI
Aprentium of the minute of				VantageBlue Direct Plan	BasicBlue Direct	
Monthly Premium (21-year old)   Size   Si	A premium is the amount you must pay each month					
Monthly Premium (40-year old)   Sala   Sa	size, and you may qualify for tax credits if you earn less					
A Priest Service Conference on the Conference on						
HOW YOU GET YOUR CARE  TOO WAS AND THE CHARGE OF THE CHARG	A Health Savings Account-qualified plan allows you to	Before tax credit				
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Additional Out-OF-Pocket  Maximum Out-OF-Pock		7	PPO	PPO	PPO	НМО
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Preventative Care		3	\$15 PCMH;	First sick visit free, all other visits	apply to deductible \$15 PCMH;	
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A Patient-Centered Medical Home (PCMH) is a team of health care providers that work together to coordinate your care. Visiting a PCMH provider may cost less in certain plans.  Lab Services, Outpatient 0% 20% 0% 20% 0% 20% 0% 20% 0% 20% 0% 20% 0% 20% 0% 20% 0% 0% 20% 0% 0% 20% 0% 0% 20% 0% 0% 20% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0	COPAYMENTS & COINSURANCE**  Copayments are fixed dollar amounts that you must pay for certain types of health care services each time you use them.  Coinsurance is a percentage of the total cost of certain types of health care services that you must pay. Coinsurance usually applies after you meet your deductible.  In TIERED plans, copayments or coinsurance for a particular service may vary depending on your choice of health provider.  The WHITE area is not subject to the deductible. It is the dollar amount or percentage you pay per visit or health care service, regardless of whether you have met your deductible.  The SHADED area is subject to the deductible. You	Primary Care Specialist Visit Preventative Care Urgent Care ER Services Inpatient Hospital X-rays & other Diag. Imaging High End Imaging: CT/PET/MRI Mental Health/Substance	\$15 PCMH; \$35 Non-PCMH \$40 \$0 \$75 \$150 \$200 per admission 0% \$150	First sick visit free, all other visits \$15 PCMH; \$25 Non-PCMH \$40 \$0 \$75 \$200 \$20% \$20%	### apply to deductible ### \$15 PCMH; ### \$25 Non-PCMH ### \$30 ### \$30 ### \$0 ### \$0% ### \$0% ### \$0% ### \$0% ### \$0% ### \$0% ### \$0% ### \$0% ### \$0%	\$20 \$40 \$0 \$40 \$200 20% 20%
team of health care providers that work together to coordinate your care. Visiting a PCMH provider may cost less in certain plans.  Skilled Nursing Facility  Support Services  Skilled Nursing Facility  Support Services  Skilled Nursing Facility  Support Services  Support Support Services  Support Support Services  Support Su	COPAYMENTS & COINSURANCE**  Copayments are fixed dollar amounts that you must pay for certain types of health care services each time you use them.  Coinsurance is a percentage of the total cost of certain types of health care services that you must pay. Coinsurance usually applies after you meet your deductible.  In TIERED plans, copayments or coinsurance for a particular service may vary depending on your choice of health provider.  The WHITE area is not subject to the deductible. It is the dollar amount or percentage you pay per visit or health care service, regardless of whether you have met your deductible.  The SHADED area is subject to the deductible. You pay the full cost of a visit or health care service until you reach your deductible amount. After that, you	Primary Care  Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits  Speech/Occup/Phys Therapy,	\$15 PCMH; \$35 Non-PCMH \$40 \$0 \$75 \$150 \$200 per admission 0% \$150 \$40	First sick visit free, all other visits \$15 PCMH; \$25 Non-PCMH \$40 \$0 \$75 \$200 \$20% \$20% \$40	### apply to deductible  ### \$15 PCMH; ### \$25 Non-PCMH  ### \$30  ### \$0  ### \$0  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ### \$0%  ##	\$20 \$40 \$0 \$40 \$200 20% 20% \$20
Outpatient Surgery/Services 0% 20% 0% 20%  Pediatric Dental Coverage Yes Yes Yes No  PRESCRIPTION DRUGS Insurance companies separate prescription drugs into different categories known as "tiers."  The "tier" of the drug identifies how much you pay for your prescription, like antibiotics or insulin. Contact HealthSource RI for more information about medication tiers.  Outpatient Surgery/Services 0% 20%  Yes Yes No  \$10  \$10  \$10  \$10  \$10  \$10  Tier 2  \$25  \$30  \$35  Tier 3  \$50  \$50  \$60  Tier 4  \$75  \$75  \$75  \$75  \$100	COPAYMENTS & COINSURANCE**  Copayments are fixed dollar amounts that you must pay for certain types of health care services each time you use them.  Coinsurance is a percentage of the total cost of certain types of health care services that you must pay. Coinsurance usually applies after you meet your deductible.  In TIERED plans, copayments or coinsurance for a particular service may vary depending on your choice of health provider.  The WHITE area is not subject to the deductible. It is the dollar amount or percentage you pay per visit or health care service, regardless of whether you have met your deductible.  The SHADED area is subject to the deductible. You pay the full cost of a visit or health care service until you reach your deductible amount. After that, you pay only the dollar amount or percentage shown.	Primary Care  Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits  Speech/Occup/Phys Therapy, Outpatient Rehab	\$15 PCMH; \$35 Non-PCMH \$40 \$0 \$75 \$150 \$200 per admission 0% \$150 \$40	First sick visit free, all other visits \$15 PCMH; \$25 Non-PCMH \$40 \$0 \$75 \$200 20% 20% \$40 20%	apply to deductible \$15 PCMH; \$25 Non-PCMH \$30 \$0 0% 0% 0% 0% 0% \$30 0%	\$20 \$40 \$0 \$40 \$200 20% 20% 20% \$20 \$40
PRESCRIPTION DRUGS Insurance companies separate prescription drugs into different categories known as "tiers." The "tier" of the drug identifies how much you pay for your prescription, like antibiotics or insulin. Contact HealthSource RI for more information about medication tiers.  Tier 1 \$10 \$10 \$10 \$10  Tier 2 \$25 \$25 \$30 \$35  Tier 3 \$50 \$50 \$0% \$60  Tier 4 \$75 \$75 \$0% \$100	COPAYMENTS & COINSURANCE**  Copayments are fixed dollar amounts that you must pay for certain types of health care services each time you use them.  Coinsurance is a percentage of the total cost of certain types of health care services that you must pay. Coinsurance usually applies after you meet your deductible.  In TIERED plans, copayments or coinsurance for a particular service may vary depending on your choice of health provider.  The WHITE area is not subject to the deductible. It is the dollar amount or percentage you pay per visit or health care service, regardless of whether you have met your deductible.  The SHADED area is subject to the deductible. You pay the full cost of a visit or health care service until you reach your deductible amount. After that, you pay only the dollar amount or percentage shown.  A Patient-Centered Medical Home (PCMH) is a team of health care providers that work together to coordinate your care. Visiting a PCMH provider may	Primary Care  Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits  Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient	\$15 PCMH; \$35 Non-PCMH \$40 \$0 \$75 \$150 \$200 per admission 0% \$150 \$40 \$40	First sick visit free, all other visits \$15 PCMH; \$25 Non-PCMH \$40 \$0 \$75 \$200 20% 20% \$40 20% \$40 20%	apply to deductible \$15 PCMH; \$25 Non-PCMH \$30  \$0  0%  0%  0%  0%  0%  \$30  0%  0%  0%  0%  0%  0%	\$20 \$40 \$0 \$40 \$200 20% 20% 20% \$20 \$40 20%
Insurance companies separate prescription drugs into different categories known as "tiers."  The "tier" of the drug identifies how much you pay for your prescription, like antibiotics or insulin. Contact HealthSource RI for more information about medication tiers.  Tier 2 \$25 \$25 \$30 \$35  Tier 3 \$50 \$50 \$0% \$60  Tier 4 \$75 \$75 \$0% \$100	COPAYMENTS & COINSURANCE**  Copayments are fixed dollar amounts that you must pay for certain types of health care services each time you use them.  Coinsurance is a percentage of the total cost of certain types of health care services that you must pay. Coinsurance usually applies after you meet your deductible.  In TIERED plans, copayments or coinsurance for a particular service may vary depending on your choice of health provider.  The WHITE area is not subject to the deductible. It is the dollar amount or percentage you pay per visit or health care service, regardless of whether you have met your deductible.  The SHADED area is subject to the deductible. You pay the full cost of a visit or health care service until you reach your deductible amount. After that, you pay only the dollar amount or percentage shown.  A Patient-Centered Medical Home (PCMH) is a team of health care providers that work together to coordinate your care. Visiting a PCMH provider may	Primary Care  Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits  Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient  Skilled Nursing Facility	\$15 PCMH; \$35 Non-PCMH \$40 \$0 \$75 \$150 \$200 per admission 0% \$150 \$40 \$40 0% \$200 per admission	First sick visit free, all other visits \$15 PCMH; \$25 Non-PCMH \$40 \$0 \$75 \$200 20% 20% 20% \$40 20% \$20% \$20%	apply to deductible \$15 PCMH; \$25 Non-PCMH \$30 \$0 0% 0% 0% 0% 0% \$30 \$30 0% \$30 0%	\$20 \$40 \$0 \$40 \$200 20% 20% \$20 \$40 20% 20%
into different categories known as "tiers."  The "tier" of the drug identifies how much you pay for your prescription, like antibiotics or insulin. Contact HealthSource RI for more information about medication tiers.  Tier 2 \$25 \$25 \$30 \$35  Tier 3 \$50 \$50 \$60  Tier 4 \$75 \$75 \$0% \$100	COPAYMENTS & COINSURANCE**  Copayments are fixed dollar amounts that you must pay for certain types of health care services each time you use them.  Coinsurance is a percentage of the total cost of certain types of health care services that you must pay. Coinsurance usually applies after you meet your deductible.  In TIERED plans, copayments or coinsurance for a particular service may vary depending on your choice of health provider.  The WHITE area is not subject to the deductible. It is the dollar amount or percentage you pay per visit or health care service, regardless of whether you have met your deductible.  The SHADED area is subject to the deductible. You pay the full cost of a visit or health care service until you reach your deductible amount. After that, you pay only the dollar amount or percentage shown.  A Patient-Centered Medical Home (PCMH) is a team of health care providers that work together to coordinate your care. Visiting a PCMH provider may	Primary Care  Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient  Skilled Nursing Facility  Outpatient Surgery/Services	\$15 PCMH; \$35 Non-PCMH \$40 \$0 \$75 \$150 \$200 per admission 0% \$150 \$40 \$40 0% \$200 per admission	First sick visit free, all other visits \$15 PCMH; \$25 Non-PCMH \$40 \$0 \$75 \$200 20% 20% \$40 20% \$40 20% 20% 20% 20% 20%	apply to deductible \$15 PCMH; \$25 Non-PCMH \$30  \$0  0%  0%  0%  0%  0%  \$30  0%  \$0%  0%  0%  \$30  0%  0%  0%  0%	\$20 \$40 \$0 \$40 \$200 20% 20% \$20 \$40 20% 20% 20%
The "tier" of the drug identifies how much you pay for your prescription, like antibiotics or insulin. Contact HealthSource RI for more information about medication tiers.  Tier 3 \$50 \$50 0% \$60  Tier 4 \$75 \$75 0% \$100	COPAYMENTS & COINSURANCE**  Copayments are fixed dollar amounts that you must pay for certain types of health care services each time you use them.  Coinsurance is a percentage of the total cost of certain types of health care services that you must pay. Coinsurance usually applies after you meet your deductible.  In TIERED plans, copayments or coinsurance for a particular service may vary depending on your choice of health provider.  The WHITE area is not subject to the deductible. It is the dollar amount or percentage you pay per visit or health care service, regardless of whether you have met your deductible.  The SHADED area is subject to the deductible. You pay the full cost of a visit or health care service until you reach your deductible amount. After that, you pay only the dollar amount or percentage shown.  A Patient-Centered Medical Home (PCMH) is a team of health care providers that work together to coordinate your care. Visiting a PCMH provider may cost less in certain plans.	Primary Care  Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits  Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient  Skilled Nursing Facility  Outpatient Surgery/Services  Pediatric Dental Coverage	\$15 PCMH; \$35 Non-PCMH \$40 \$0 \$75 \$150 \$200 per admission 0% \$150 \$40 \$40 0% \$200 per admission 0%	First sick visit free, all other visits \$15 PCMH; \$25 Non-PCMH \$40 \$0 \$75 \$200 20% 20% 20% \$40 20% \$40 20% \$40 20% \$40 40% 40% 40% 40% 40% 40% 40% 40% 40% 4	apply to deductible \$15 PCMH; \$25 Non-PCMH \$30 \$0 0% 0% 0% 0% 0% \$30 0% \$30 0% 0%  0% 40% 0% 0% 0% 7yes	\$20 \$40 \$0 \$40 \$200 20% 20% 20% \$20 \$40 20% 20% 20%
about medication tiers.  Tier 4 \$75 \$75 0% \$100	COPAYMENTS & COINSURANCE**  Copayments are fixed dollar amounts that you must pay for certain types of health care services each time you use them.  Coinsurance is a percentage of the total cost of certain types of health care services that you must pay. Coinsurance usually applies after you meet your deductible.  In TIERED plans, copayments or coinsurance for a particular service may vary depending on your choice of health provider.  The WHITE area is not subject to the deductible. It is the dollar amount or percentage you pay per visit or health care service, regardless of whether you have met your deductible.  The SHADED area is subject to the deductible. You pay the full cost of a visit or health care service until you reach your deductible amount. After that, you pay only the dollar amount or percentage shown.  A Patient-Centered Medical Home (PCMH) is a team of health care providers that work together to coordinate your care. Visiting a PCMH provider may cost less in certain plans.  PRESCRIPTION DRUGS  Insurance companies separate prescription drugs	Primary Care  Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient  Skilled Nursing Facility  Outpatient Surgery/Services  Pediatric Dental Coverage  Tier 1	\$15 PCMH; \$35 Non-PCMH \$40 \$0 \$75 \$150 \$200 per admission 0% \$150 \$40 \$40 0% \$200 per admission 0% \$200 per admission	First sick visit free, all other visits \$15 PCMH; \$25 Non-PCMH \$40 \$0 \$75 \$200 20% 20% 20% \$40 20% \$40 20% \$40 40 40 40% 40% 40% 40% 40% 40% 40% 40%	apply to deductible \$15 PCMH; \$25 Non-PCMH \$30 \$0 0% 0% 0% 0% 0% \$30 0% \$30 0% 0% 430 0% 0% 7es	\$20 \$40 \$0 \$40 \$200 20% 20% 20% \$20 \$40 20% 20% 20%
Tier 5 \$125 \$125 0% N/A	COPAYMENTS & COINSURANCE**  Copayments are fixed dollar amounts that you must pay for certain types of health care services each time you use them.  Coinsurance is a percentage of the total cost of certain types of health care services that you must pay. Coinsurance usually applies after you meet your deductible.  In TIERED plans, copayments or coinsurance for a particular service may vary depending on your choice of health provider.  The WHITE area is not subject to the deductible. It is the dollar amount or percentage you pay per visit or health care service, regardless of whether you have met your deductible.  The SHADED area is subject to the deductible. You pay the full cost of a visit or health care service until you reach your deductible amount. After that, you pay only the dollar amount or percentage shown.  A Patient-Centered Medical Home (PCMH) is a team of health care providers that work together to coordinate your care. Visiting a PCMH provider may cost less in certain plans.  PRESCRIPTION DRUGS  Insurance companies separate prescription drugs into different categories known as "tiers."  The "tier" of the drug identifies how much you pay for your prescription, like antibiotics or insulin.	Primary Care  Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits  Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient  Skilled Nursing Facility  Outpatient Surgery/Services  Pediatric Dental Coverage  Tier 1  Tier 2	\$15 PCMH; \$35 Non-PCMH \$40 \$0 \$75 \$150 \$200 per admission 0% \$150 \$40 \$40 0% \$200 per admission 0% \$2150 \$2150 \$2150 \$2150 \$2150 \$2150 \$225	First sick visit free, all other visits \$15 PCMH; \$25 Non-PCMH \$40 \$0 \$75 \$200 20% 20% 20% \$40 20% \$40 20% \$40 40% \$10 \$20% \$20%	apply to deductible \$15 PCMH; \$25 Non-PCMH \$30 \$0 0% 0% 0% 0% 0% \$30 0% \$30 0%  0%  40% 0% 530 0% 74es \$10 \$30	\$20 \$40 \$0 \$40 \$200 20% 20% 20% \$20 \$40 20% 20% 20% No \$10 \$35
	COPAYMENTS & COINSURANCE**  Copayments are fixed dollar amounts that you must pay for certain types of health care services each time you use them.  Coinsurance is a percentage of the total cost of certain types of health care services that you must pay. Coinsurance usually applies after you meet your deductible.  In TIERED plans, copayments or coinsurance for a particular service may vary depending on your choice of health provider.  The WHITE area is not subject to the deductible. It is the dollar amount or percentage you pay per visit or health care service, regardless of whether you have met your deductible.  The SHADED area is subject to the deductible. You pay the full cost of a visit or health care service until you reach your deductible amount. After that, you pay only the dollar amount or percentage shown.  A Patient-Centered Medical Home (PCMH) is a team of health care providers that work together to coordinate your care. Visiting a PCMH provider may cost less in certain plans.  PRESCRIPTION DRUGS  Insurance companies separate prescription drugs into different categories known as "tiers."  The "tier" of the drug identifies how much you pay for your prescription, like antibiotics or insulin. Contact HealthSource RI for more information	Primary Care  Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient  Skilled Nursing Facility  Outpatient Surgery/Services  Pediatric Dental Coverage  Tier 1  Tier 2  Tier 3	\$15 PCMH; \$35 Non-PCMH \$40 \$0 \$75 \$150 \$200 per admission 0% \$150 \$40 \$40 0% \$200 per admission 0% \$2100 per admission 0% \$25 \$50	First sick visit free, all other visits \$15 PCMH; \$25 Non-PCMH  \$40  \$0  \$75  \$200  20%  20%  20%  \$40  20%  \$40  20%  \$10  \$20%	apply to deductible \$15 PCMH; \$25 Non-PCMH \$30  \$0  0%  0%  0%  0%  0%  \$30  0%  0%  \$40  0%  0%  \$40  0%  0%  0%  0%  0%  0%  0%  0%  0%	\$20 \$40 \$0 \$40 \$200 20% 20% 20% \$20 \$40 20% 20% 20% No \$10 \$35

Nearly 9 out of 10 HealthSource RI customers received financial help this year. Use our Savings Calculator at HealthSourceRI.com/calculator to see if you qualify.



Insurance Company	NHPRI	UHC	UHC	UHC	BCBSRI
Plan Name	*Neighborhood PRINCIPAL	Gold Compass HSA 1500	Gold Compass 1000	Gold Choice 1500 <sup>2</sup>	*BlueSolutions for HSA Direct 3900/7800
Metal Level	GOLD	GOLD	GOLD	GOLD	SILVER
Monthly Premium (21-year old) Before tax credit	\$271	\$250	\$271	\$284	\$213
Monthly Premium (40-year old) Before tax credit	\$346	\$319	\$347	\$364	\$273
Monthly Premium (60-year old) Before tax credit	\$735	\$678	\$736	\$772	\$579
HSA Qualified		<b>√</b>			<b>✓</b>
Plan Type (see definitions on reverse)	НМО	НМО	НМО	НМО	PPO
Referral Required	No	Yes	Yes	No	No
Network Coverage Area	RI only	RI only	RI only	National	National
RI Provider Information (subject to change)	1,364 PCPs/ pediatricians 5,808 specialists 15 of 15 hospitals	1,076 PCPs/ pediatricians 4,711 specialists 14 of 15 hospitals 445 dentists	1,076 PCPs/ pediatricians 4,711 specialists 14 of 15 hospitals 445 dentists	1,304 PCPs/ pediatricians 5,321 specialists 15 of 15 hospitals 445 dentists	1,234 PCPs/ pediatricians 4,244 specialists 15 of 15 hospitals 582 dentists
Out of Network Coverage, Non-Emergency	Not covered except for urgent or emergent care	Not covered except for urgent or emergent care	Not covered except for urgent or emergent care	Not covered except for urgent or emergent care	Yes – 30% Coinsurance
Maximum Out-Of-Pocket (MOOP) Medical + Drug	\$2,500 Individual \$5,000 Family	\$3,000 Individual \$6,000 Family	\$4,000 Individual \$8,000 Family	\$4,000 Individual \$8,000 Family	\$4,300 Individual \$8,600 Family
Deductible - Medical	\$1,500 Individual	\$1,500 Individual	\$1,000 Individual	\$1,500 Individual	\$3,900 Individual
Deductible - Medical	\$3,000 Family	\$3,000 Family	\$2,000 Family	\$3,000 Family	\$7,800 Family
Deductible - Integral	\$3,000 Family \$0	\$3,000 Family  Combined with Medical	\$2,000 Family \$0	\$3,000 Family \$0	\$7,800 Family  Combined with Medical
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Deductible - Drug	\$0	Combined with Medical	\$0	\$0	Combined with Medical
Deductible - Drug Primary Care	\$0 \$25	Combined with Medical	\$0 \$20	\$0 \$20	Combined with Medical
Deductible - Drug Primary Care Specialist Visit	\$0 \$25 \$40	Combined with Medical \$20 \$40	\$0 \$20 \$40	\$0 \$20 \$40	Combined with Medical 10% 10%
Deductible - Drug  Primary Care  Specialist Visit  Preventative Care	\$0 \$25 \$40 \$0	Combined with Medical \$20 \$40 \$0	\$0 \$20 \$40 \$0	\$0 \$20 \$40 \$0	Combined with Medical 10% 10% \$0
Deductible - Drug  Primary Care  Specialist Visit  Preventative Care  Urgent Care	\$0 \$25 \$40 \$0 \$40	\$20 \$40 \$0 \$75	\$0 \$20 \$40 \$0 \$100	\$0 \$20 \$40 \$0 \$75	Combined with Medical 10% 10% \$0 10%
Deductible - Drug  Primary Care  Specialist Visit  Preventative Care  Urgent Care  ER Services	\$0 \$25 \$40 \$0 \$40 \$200	\$20 \$40 \$0 \$75 \$100 \$250/day to	\$0 \$20 \$40 \$0 \$100 \$200	\$0 \$20 \$40 \$0 \$75 \$150	Combined with Medical 10% 10% \$0 10% 10%
Deductible - Drug  Primary Care  Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital	\$0 \$25 \$40 \$0 \$40 \$200 5%	\$20 \$40 \$0 \$75 \$100 \$250/day to \$1000/admission	\$0 \$20 \$40 \$0 \$100 \$200 20%	\$0 \$20 \$40 \$0 \$75 \$150	Combined with Medical 10% 10% \$0 10% 10% 10%
Deductible - Drug  Primary Care  Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance	\$0 \$25 \$40 \$0 \$40 \$200 5%	\$20 \$40 \$0 \$75 \$100 \$250/day to \$1000/admission	\$0 \$20 \$40 \$0 \$100 \$200 20%	\$0 \$20 \$40 \$0 \$75 \$150 0% \$20	Combined with Medical 10% 10% \$0 10% 10% 10% 10%
Deductible - Drug  Primary Care  Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI	\$0 \$25 \$40 \$0 \$40 \$200 5% 5%	\$20 \$40 \$0 \$75 \$100 \$1000/admission 0% Tier 1; \$100 Tier 2	\$0 \$20 \$40 \$0 \$100 \$200 20% 20%	\$0 \$20 \$40 \$0 \$75 \$150 0% \$20 0% Tier 1; \$250 in addition to deductible¹ Tier 2	Combined with Medical 10% 10% \$0 10% 10% 10% 10% 10%
Deductible - Drug  Primary Care  Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy,	\$0 \$25 \$40 \$0 \$40 \$200 5% 5% 5% \$25	\$20 \$40 \$0 \$75 \$100 \$250/day to \$1000/admission 0% 0% Tier 1; \$100 Tier 2	\$0 \$20 \$40 \$0 \$100 \$200 20% 20% \$40	\$0 \$20 \$40 \$0 \$75 \$150 0% \$20 0% Tier 1; \$250 in addition to deductible¹ Tier 2	Combined with Medical 10% 10% \$0 10% 10% 10% 10% 10% 10%
Deductible - Drug  Primary Care  Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits  Speech/Occup/Phys Therapy, Outpatient Rehab	\$0 \$25 \$40 \$0 \$40 \$200 5% 5% 5% \$25 \$40	\$20 \$40 \$0 \$75 \$100 \$250/day to \$1000/admission 0% 0% Tier 1; \$100 Tier 2 \$40 0%	\$0 \$20 \$40 \$0 \$100 \$200 20% 20% 20% \$40 20%	\$0 \$20 \$40 \$0 \$75 \$150 0% \$20 0% Tier 1; \$250 in addition to deductible Tier 2 \$40 0%	Combined with Medical 10% 10% \$0 10% 10% 10% 10% 10% 10% 10%
Deductible - Drug  Primary Care  Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient	\$0 \$25 \$40 \$0 \$40 \$200 5% 5% \$5% \$25 \$40 5%	\$20 \$40 \$0 \$75 \$100 \$250/day to \$1000/admission  0%  0% Tier 1; \$100 Tier 2 \$40  0%  0% \$250/day to	\$0 \$20 \$40 \$0 \$100 \$200 20% 20% \$40 20%	\$0 \$20 \$40 \$0 \$75 \$150 0% \$20 0% Tier 1; \$250 in addition to deductible Tier 2 \$40 0% 0%	Combined with Medical  10%  10%  \$0  10%  10%  10%  10%  10%
Primary Care Specialist Visit Preventative Care Urgent Care ER Services Inpatient Hospital X-rays & other Diag. Imaging High End Imaging: CT/PET/MRI Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab Lab Services, Outpatient Skilled Nursing Facility	\$0 \$25 \$40 \$0 \$40 \$200 5% 5% 5% \$25 \$40 5% 5%	\$20 \$40 \$0 \$75 \$100 \$250/day to \$1000/admission  0%  0% Tier 1; \$100 Tier 2 \$40  0% \$250/day to \$1000/admission	\$0 \$20 \$40 \$0 \$100 \$200 20% 20% 20% \$40 20% 20%	\$0 \$20 \$40 \$0 \$75 \$150 0% \$20 0% Tier 1; \$250 in addition to deductible Tier 2 \$40 0% 0% 0% 0%	Combined with Medical  10%  10%  \$0  10%  10%  10%  10%  10%
Deductible - Drug  Primary Care  Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient  Skilled Nursing Facility  Outpatient Surgery/Services	\$0 \$25 \$40 \$0 \$40 \$200 5% 5% \$25 \$40 5% 5%	\$20 \$40 \$0 \$75 \$100 \$250/day to \$1000/admission  0%  0%  0%  \$250/day to \$1000/admission  0%  0%  Tier 1; \$100 Tier 2 \$40  0% \$250/day to \$1000/admission	\$0 \$20 \$40 \$0 \$100 \$200 20% 20% 20% \$40 20% 20% 20%	\$0 \$20 \$40 \$0 \$75 \$150  0% \$20  0% Tier 1; \$250 in addition to deductible Tier 2 \$40  0%  0%  0%  0%  0%  0%  1ier 1; \$250 in addition to deductible Tier 2	Combined with Medical  10%  10%  \$0  10%  10%  10%  10%  10%
Primary Care  Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient  Skilled Nursing Facility  Outpatient Surgery/Services  Pediatric Dental Coverage	\$0 \$25 \$40 \$0 \$40 \$200 5% 5% \$25 \$40 5% 5% \$5%	\$20 \$40 \$0 \$75 \$100 \$250/day to \$1000/admission 0% 0% Tier 1; \$100 Tier 2 \$40 0% \$250/day to \$1000/admission	\$0 \$20 \$40 \$0 \$100 \$200 20% 20% 20% \$40 20% 20% 20% 20%	\$0 \$20 \$40 \$0 \$75 \$150 0% \$20 0% Tier 1; \$250 in addition to deductible¹ Tier 2 \$40 0% 0% 0% 10% 10% 10% 10% 10% 10% 10% 1	Combined with Medical 10% 10% \$0 10% 10% 10% 10% 10% 10% 10% 10% 10% 10
Primary Care Specialist Visit Preventative Care Urgent Care ER Services Inpatient Hospital X-rays & other Diag. Imaging High End Imaging: CT/PET/MRI Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab Lab Services, Outpatient Skilled Nursing Facility Outpatient Surgery/Services Pediatric Dental Coverage Tier 1	\$0 \$25 \$40 \$0 \$40 \$200 5% 5% 5% \$25 \$40 5% 5% 5%	\$20 \$40 \$0 \$75 \$100 \$250/day to \$1000/admission  0%  0% Tier 1; \$100 Tier 2 \$40  0% \$250/day to \$1000/admission  0%  Yes \$100 Tier 1; \$100 Tier 2	\$0 \$20 \$40 \$0 \$100 \$200 20% 20% 20% 20% 20% 20% 20% 20%	\$0 \$20 \$40 \$0 \$75 \$150 0% \$20 0% Tier 1; \$250 in addition to deductible Tier 2 \$40 0% 0% 0% Tier 1; \$250 in addition to deductible Tier 2  \$41	Combined with Medical  10%  10%  \$0  10%  10%  10%  10%  10%
Primary Care Specialist Visit Preventative Care Urgent Care ER Services Inpatient Hospital X-rays & other Diag. Imaging High End Imaging: CT/PET/MRI Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab Lab Services, Outpatient Skilled Nursing Facility Outpatient Surgery/Services Pediatric Dental Coverage Tier 1 Tier 2	\$0 \$25 \$40 \$0 \$40 \$200 5% 5% 5% \$25 \$40 5% 5% No \$10 \$35	\$20 \$40 \$0 \$75 \$100 \$250/day to \$1000/admission  0%  0% Tier 1; \$100 Tier 2 \$40  0% \$250/day to \$1000/admission  0%  \$250/day to \$1000/admission	\$0 \$20 \$40 \$0 \$100 \$200 20% 20% 20% \$40 20% 20% 20% 20% Yes	\$0 \$20 \$40 \$0 \$75 \$150 0% \$20 0% Tier 1; \$250 in addition to deductible¹ Tier 2 \$40 0% 0% 0% \$20  0% Tier 1; \$250 in addition to deductible¹ Tier 2 \$41 \$42 \$44 \$44 \$45 \$45 \$45 \$45 \$45 \$45 \$45 \$45	Combined with Medical  10%  10%  \$0  10%  10%  10%  10%  10%

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Insurance Company	BCBSRI	BCBSRI	BCBSRI	NHPRI	NHPRI
Plan Name	VantageBlue Direct Plan 3000/6000	BasicBlue Direct 4900/9800	BlueCHIP Direct 4500/9000	Neighborhood COMMUNITY	*Neighborhood VALUE
Metal Level	SILVER	SILVER	SILVER	SILVER	SILVER
Monthly Premium (21-year old) Before tax credit	\$263	\$218	\$206	\$203	\$217
Monthly Premium (40-year old) Before tax credit	\$336	\$279	\$263	\$259	\$277
Monthly Premium (60-year old) Before tax credit	\$713	\$592	\$558	\$550	\$589
HSA Qualified				<b>√</b>	
Plan Type (see definitions on reverse)	PPO	PPO	POS	НМО	НМО
Referral Required	No	No	Yes	No	No
Network Coverage Area	National	National	RI only	RI only	RI only
RI Provider Information	1,234 PCPs/	1,234 PCPs/	1,234 PCPs/	1,364 PCPs/	1,364 PCPs/
(subject to change)	pediatricians 4,244 specialists	pediatricians 4,244 specialists	pediatricians 4,244 specialists	pediatricians 5,808 specialists	pediatricians 5,808 specialists
	15 of 15 hospitals	15 of 15 hospitals	15 of 15 hospitals	15 of 15 hospitals	15 of 15 hospitals
	582 dentists	582 dentists	582 dentists		
Out of Network Coverage, Non-Emergency	Yes – 40% Coinsurance	Not covered except for urgent or emergent care	Not covered except for urgent or emergent care	Not covered except for urgent or emergent care	Not covered except for urgent or emergent care
Maximum Out-Of-Pocket (MOOP) Medical + Drug	\$6,800 Individual \$13,600 Family	\$5,500 Individual \$11,000 Family	\$5,200 Individual \$10,400 Family	\$4,000 Individual \$8,000 Family	\$6,550 Individual \$13,100 Family
Deductible - Medical	\$3,000 Individual \$6,000 Family	\$4,900 Individual \$9,800 Family	\$4,500 Individual \$9,000 Family	\$2,750 Individual \$5,500 Family	\$3,000 Individual \$6,000 Family
Deductible - Drug	\$0	Only tiers 3, 4 and 5 apply to deductible	Only tiers 3, 4 and 5 apply to deductible	Combined with Medical	\$0
Primary Care	First sick visit free, all other visits \$20 PCMH; \$40 Non-PCMH	\$10 PCMH; \$20 Non-PCMH	\$30 PCMH; \$50 Non-PCMH	10%	\$25
Specialist Visit	¢ee	\$45	\$60	10%	\$40
	\$55	Ψ10		10 /0	Ψ-0
Preventative Care	\$0	\$0	\$0	\$0	\$0
<u> </u>			\$0 \$75		
Preventative Care	\$0	\$0		\$0	\$0
Preventative Care Urgent Care	\$0 \$75	\$0 \$75	\$75	\$0 10%	\$0 \$40
Preventative Care Urgent Care ER Services	\$0 \$75 \$200	\$0 \$75 10%	\$75 10%	\$0 10% 10%	\$0 \$40 \$200
Preventative Care Urgent Care ER Services Inpatient Hospital	\$0 \$75 \$200 20%	\$0 \$75 10%	\$75 10% 10%	\$0 10% 10% 10%	\$0 \$40 \$200 20%
Preventative Care Urgent Care ER Services Inpatient Hospital X-rays & other Diag. Imaging High End Imaging: CT/PET/MRI Mental Health/Substance	\$0 \$75 \$200 20% 20%	\$0 \$75 10% 10%	\$75 10% 10% 10%	\$0 10% 10% 10%	\$0 \$40 \$200 20% 20%
Preventative Care Urgent Care ER Services Inpatient Hospital X-rays & other Diag. Imaging High End Imaging: CT/PET/MRI Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy,	\$0 \$75 \$200 20% 20%	\$0 \$75 10% 10% 10%	\$75 10% 10% 10%	\$0 10% 10% 10% 10%	\$0 \$40 \$200 20% 20%
Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits	\$0 \$75 \$200 20% 20% 20% \$55	\$0 \$75 10% 10% 10% \$45	\$75 10% 10% 10% 10% \$60	\$0 10% 10% 10% 10% 10%	\$0 \$40 \$200 20% 20% 20% \$25
Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab	\$0 \$75 \$200 20% 20% 20% \$55	\$0 \$75 10% 10% 10% \$45 10%	\$75 10% 10% 10% 10% \$60 10%	\$0 10% 10% 10% 10% 10%	\$0 \$40 \$200 20% 20% 20% \$25 \$40
Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient	\$0 \$75 \$200 20% 20% 20% \$55 20%	\$0 \$75 10% 10% 10% \$45 10%	\$75 10% 10% 10% 10% \$60 10%	\$0 10% 10% 10% 10% 10% 10% 10%	\$0 \$40 \$200 20% 20% 20% \$25 \$40 20%
Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient  Skilled Nursing Facility	\$0 \$75 \$200 20% 20% 20% \$55 20% 20%	\$0 \$75 10% 10% 10% \$45 10% 10%	\$75 10% 10% 10% 10% \$60 10% 10%	\$0 10% 10% 10% 10% 10% 10% 10% 10%	\$0 \$40 \$200 20% 20% 20% \$25 \$40 20%
Preventative Care  Urgent Care  ER Services Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient  Skilled Nursing Facility  Outpatient Surgery/Services	\$0 \$75 \$200 20% 20% 20% \$55 20% 20% 20%	\$0 \$75 10% 10% 10% \$45 10% 10% 10%	\$75 10% 10% 10% \$60 10% 10% 10%	\$0 10% 10% 10% 10% 10% 10% 10% 10% 10%	\$0 \$40 \$200 20% 20% 20% \$25 \$40 20% 20%
Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient  Skilled Nursing Facility  Outpatient Surgery/Services  Pediatric Dental Coverage	\$0 \$75 \$200 20% 20% 20% \$55 20% 20% 20% Yes	\$0 \$75 10% 10% 10% \$45 10% 10% 10% Yes	\$75 10% 10% 10% 10% \$60 10% 10% 10% Yes	\$0 10% 10% 10% 10% 10% 10% 10% 10% No	\$0 \$40 \$200 20% 20% 20% \$25 \$40 20% 20% No
Preventative Care  Urgent Care  ER Services Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient  Skilled Nursing Facility  Outpatient Surgery/Services  Pediatric Dental Coverage  Tier 1	\$0 \$75 \$200 20% 20% 20% \$55 20% 20% 20% 20% Yes	\$0 \$75 10% 10% 10% \$45 10% 10% 10% Yes \$10	\$75 10% 10% 10% 10% \$60 10% 10% 10% Yes \$10	\$0 10% 10% 10% 10% 10% 10% 10% 10% No \$10	\$0 \$40 \$200 20% 20% 20% \$25 \$40 20% 20% No \$15
Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient  Skilled Nursing Facility  Outpatient Surgery/Services  Pediatric Dental Coverage  Tier 1  Tier 2	\$0 \$75 \$200 20% 20% 20% \$55 20% 20% 20% Yes \$10 \$35	\$0 \$75 10% 10% 10% \$45 10% 10% 10% Yes \$10 \$30	\$75 10% 10% 10% 10% \$60 10% 10% 10%  10% \$10% \$30	\$0 10% 10% 10% 10% 10% 10% 10% 10% 10% 10	\$0 \$40 \$200 20% 20% 20% \$25 \$40 20% 20% No \$15

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Insurance Company	UHC	UHC	UHC	BCBSRI	BCBSRI
Plan Name	Silver Compass HSA 2500	Silver Compass 3000	Silver Choice 2500 <sup>2</sup>	BlueSolutions for HSA Direct 3700/7400	*BlueSolutions for HSA Direct 5350/10700
Metal Level	SILVER	SILVER	SILVER	BRONZE	BRONZE
Monthly Premium (21-year old) Before tax credit	\$213	\$237	\$250	\$188	\$183
Monthly Premium (40-year old) Before tax credit	\$273	\$303	\$320	\$241	\$234
Monthly Premium (60-year old) Before tax credit	\$579	\$644	\$679	\$511	\$497
HSA Qualified	<b>√</b>			<b>√</b>	<b>√</b>
Plan Type (see definitions on reverse)	НМО	НМО	НМО	PPO	PPO
Referral Required	Yes	Yes	No	No	No
Network Coverage Area	RI only	RI only	National	National	National
RI Provider Information	1,076 PCPs/ pediatricians	1,076 PCPs/ pediatricians	1,304 PCPs/ pediatricians	1,234 PCPs/ pediatricians	1,234 PCPs/ pediatricians
(subject to change)	4,711 specialists	4,711 specialists	5,321 specialists	4,244 specialists	4,244 specialists
	14 of 15 hospitals	14 of 15 hospitals	15 of 15 hospitals	15 of 15 hospitals	15 of 15 hospitals
	445 dentists	445 dentists	445 dentists	582 dentists	582 dentists
Out of Network Coverage, Non-Emergency	Not covered except for urgent or emergent care	Not covered except for urgent or emergent care	Not covered except for urgent or emergent care	Yes – 60% Coinsurance	Yes – 40% Coinsurance
Maximum Out-Of-Pocket (MOOP) Medical + Drug	\$6,250 Individual \$6,850 Family	\$6,600 Individual \$13,200 Family	\$6,250 Individual \$12,500 Family	\$6,550 Individual \$13,100 Family	\$6,550 Individual \$13,100 Family
Deductible - Medical	\$2,500 Individual \$6,250 Family	\$3,000 Individual \$6,000 Family	\$2,500 Individual \$5,000 Family	\$3,700 Individual \$7,400 Family	\$5,350 Individual \$10,700 Family
Deductible - Drug	Combined with Medical	\$0	\$0	Combined with Medical	Combined with Medical
Primary Care	\$35	\$30	\$35	50%	0%
Specialist Visit	\$70	\$60	\$70	50%	0%
Preventative Care	\$0	\$0	\$0	\$0	\$0
Urgent Care	\$75	\$100	\$75	50%	0%
ER Services	\$150	\$200	20%	50%	0%
Inpatient Hospital	\$500 per Inpatient Stay	20%	20%	50%	0%
X-rays & other Diag. Imaging	0%	20%	20%	50%	0%
High End Imaging: CT/PET/MRI	\$150 Tier 1; \$250 Tier 2	20%	20% Tier 1; \$250 in addition to deductible Tier 2	50%	0%
Mental Health/Substance Abuse - Office Visits	\$70	\$60	\$70	50%	0%
Speech/Occup/Phys Therapy, Outpatient Rehab	0%	20%	20%	50%	0%
Lab Services, Outpatient	0%	20%	20%	50%	0%
Skilled Nursing Facility	\$500 per Inpatient Stay	20%	20%	50%	0%
Outpatient Surgery/Services	\$150 Tier 1; \$250 Tier 2	20%	20% Tier 1; \$250 in addition to deductible Tier 2	50%	0%
Pediatric Dental Coverage	Yes	Yes	Yes	Yes	Yes
Tier 1	\$15	\$15	\$15	\$10	\$10
Tier 2	\$40	\$40	\$40	\$35	\$35
T: 0					
Tier 3	\$70	\$70	\$70	\$60	\$60
Tier 4	\$70 \$100	\$70 \$100	\$70 \$100	\$60 \$100	\$60 \$100

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Insurance Company	BCBSRI	NHPRI	NHPRI	UHC	UHC
Plan Name	BasicBlue Direct 6850/13700	Neighborhood SECURE	*Neighborhood ECONOMY	Bronze Compass HSA 5600	Bronze Choice HSA 5600 <sup>2</sup>
Metal Level	BRONZE	BRONZE	BRONZE	BRONZE	BRONZE
Monthly Premium (21-year old) Before tax credit	\$182	\$159	\$158	\$186	\$203
Monthly Premium (40-year old) Before tax credit	\$233	\$204	\$203	\$238	\$259
Monthly Premium (60-year old) Before tax credit	\$494	\$433	\$430	\$505	\$550
HSA Qualified		<b>√</b>	<b>√</b>	<b>√</b>	<b>√</b>
Plan Type (see definitions on reverse)	PPO	НМО	НМО	НМО	НМО
Referral Required	No	No	No	Yes	No
Network Coverage Area	National	RI only	RI only	RI only	National
RI Provider Information (subject to change)	1,234 PCPs/ pediatricians 4,244 specialists 15 of 15 hospitals 582 dentists	1,364 PCPs/ pediatricians 5,808 specialists 15 of 15 hospitals	1,364 PCPs/ pediatricians 5,808 specialists 15 of 15 hospitals	1,076 PCPs/ pediatricians 4,711 specialists 14 of 15 hospitals 445 dentists	1,304 PCPs/ pediatricians 5,321 specialists 15 of 15 hospitals 445 dentists
Out of Network Coverage, Non-Emergency	Not covered except for urgent or emergent care	Not covered except for urgent or emergent care	Not covered except for urgent or emergent care	Not covered except for urgent or emergent care	Not covered except for urgent or emergent care
Maximum Out-Of-Pocket (MOOP) Medical + Drug	\$6,850 Individual \$13,700 Family	\$6,550 Individual \$13,100 Family	\$6,550 Individual \$13,100 Family	\$6,500 Individual \$13,000 Family	\$6,500 Individual \$13,000 Family
Deductible - Medical	\$6,850 Individual \$13,700 Family	\$4,900 Individual \$9,800 Family	\$6,000 Individual \$12,000 Family	\$5,600 Individual \$11,200 Family	\$5,600 Individual \$11,200 Family
Deductible - Drug	Only tiers 3, 4 and 5 apply to deductible	Combined with Medical	Combined with Medical	Combined with Medical	Combined with Medical
Primary Care	\$50 PCMH;	220/	0%	0%	20/
ary Sars	\$70 Non-PCMH	20%	0 70	0%	0%
Specialist Visit		20%	0%	0%	0%
	\$70 Non-PCMH				
Specialist Visit	\$70 Non-PCMH \$85	20%	0%	0%	0%
Specialist Visit Preventative Care	\$70 Non-PCMH \$85 \$0	20%	0%	0%	0%
Specialist Visit  Preventative Care  Urgent Care	\$70 Non-PCMH \$85 \$0 0%	20% \$0 20%	0% \$0 0%	0% \$0 0%	0% \$0 0%
Specialist Visit Preventative Care Urgent Care ER Services	\$70 Non-PCMH \$85 \$0 0%	20% \$0 20% 20%	0% \$0 0%	0% \$0 0%	0% \$0 0%
Specialist Visit Preventative Care Urgent Care ER Services Inpatient Hospital X-rays & other Diag. Imaging High End Imaging: CT/PET/MRI	\$70 Non-PCMH \$85 \$0 0% 0%	20% \$0 20% 20% 20%	0% \$0 0% 0%	0% \$0 0% 0%	0% \$0 0% 0%
Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance  Abuse - Office Visits	\$70 Non-PCMH \$85 \$0 0% 0% 0% 0%	20% \$0 20% 20% 20%	0% \$0 0% 0% 0%	0% \$0 0% 0% 0%	0% \$0 0% 0% 0%
Specialist Visit Preventative Care Urgent Care ER Services Inpatient Hospital X-rays & other Diag. Imaging High End Imaging: CT/PET/MRI Mental Health/Substance	\$70 Non-PCMH \$85 \$0 0% 0% 0% 0% 0%	20% \$0 20% 20% 20% 20%	0% \$0 0% 0% 0% 0%	0% \$0 0% 0% 0% 0%	0% \$0 0% 0% 0% 0%
Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy,	\$70 Non-PCMH \$85 \$0 0% 0% 0% 0% 0% \$0%	20% \$0 20% 20% 20% 20% 20%	0% \$0 0% 0% 0% 0% 0% 0%	0% \$0 0% 0% 0% 0%	0% \$0 0% 0% 0% 0%
Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab	\$70 Non-PCMH \$85 \$0 0% 0% 0% 0% 0% \$0%	20% \$0 20% 20% 20% 20% 20% 20%	0% \$0 0% 0% 0% 0% 0% 0% 0% 0%	0% \$0 0% 0% 0% 0% 0% 0% 0%	0% \$0 0% 0% 0% 0% 0% 0% 0%
Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient	\$70 Non-PCMH \$85 \$0 0% 0% 0% 0% 0% \$85 0% 0% \$85	20% \$0 20% 20% 20% 20% 20% 20% 20%	0% \$0 0% 0% 0% 0% 0% 0% 0% 0% 0%	0% \$0 0% 0% 0% 0% 0% 0% 0% 0%	0% \$0 0% 0% 0% 0% 0% 0% 0% 0%
Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient  Skilled Nursing Facility	\$70 Non-PCMH \$85 \$0 0% 0% 0% 0% 0% \$85 0% 0% 0%	20% \$0 20% 20% 20% 20% 20% 20% 20% 20	0% \$0 0% 0% 0% 0% 0% 0% 0% 0% 0% 0%	0% \$0 0% 0% 0% 0% 0% 0% 0% 0% 0%	0% \$0 0% 0% 0% 0% 0% 0% 0% 0% 0% 0%
Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient  Skilled Nursing Facility  Outpatient Surgery/Services	\$70 Non-PCMH \$85 \$0 0% 0% 0% 0% 0% \$85 0% 0% 0% 0% 0% 0%	20% \$0 20% 20% 20% 20% 20% 20% 20% 20% 20% 20	0% \$0 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0%	0% \$0 0% 0% 0% 0% 0% 0% 0% 0% 0% 0%	0% \$0 0% 0% 0% 0% 0% 0% 0% 0% 0% 0%
Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient  Skilled Nursing Facility  Outpatient Surgery/Services  Pediatric Dental Coverage	\$70 Non-PCMH \$85 \$0 0% 0% 0% 0% 0% \$85 0% 0% \$85 0% 0% 40% 0% 79es	20% \$0 20% 20% 20% 20% 20% 20% 20% 20% 20% No	0% \$0 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% No	0% \$0 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0%	0% \$0 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 40% 0% 0% 0% 40% 4
Specialist Visit  Preventative Care  Urgent Care  ER Services  Inpatient Hospital  X-rays & other Diag. Imaging  High End Imaging: CT/PET/MRI  Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab  Lab Services, Outpatient  Skilled Nursing Facility  Outpatient Surgery/Services  Pediatric Dental Coverage  Tier 1	\$70 Non-PCMH \$85 \$0 0% 0% 0% 0% 0% \$85 0% 0% \$85 0% 0% 4 0% 585 0% 585 0% 586 0% 586 0% 0% 587	20% \$0 20% 20% 20% 20% 20% 20% 20% 20% 20% No \$10	0% \$0 0% 0% 0% 0% 0% 0% 0% 0% 0% No \$10	0% \$0 0% 0% 0% 0% 0% 0% 0% 0% 0% Ves \$15	0% \$0 0% 0% 0% 0% 0% 0% 0% 0% 0% Ves
Specialist Visit Preventative Care Urgent Care ER Services Inpatient Hospital X-rays & other Diag. Imaging High End Imaging: CT/PET/MRI Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab Lab Services, Outpatient Skilled Nursing Facility Outpatient Surgery/Services Pediatric Dental Coverage Tier 1 Tier 2	\$70 Non-PCMH \$85 \$0 0% 0% 0% 0% 0% \$85 0% 0% \$85  0% 0% \$85 10 \$50	20% \$0 20% 20% 20% 20% 20% 20% 20% 20% 20% No \$10 \$35	0% \$0 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% No \$10	0% \$0 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% Ves \$15 \$40	0% \$0 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% Ves \$15 \$40