





- 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



COST SHARING REDUCTION PLANS FOR ELIGIBLE INDIVIDUALS AND FAMILIES

Cost Sharing Reduction (CSR) Plans:

CSR plans are Silver plans that have reduced deductibles, coinsurance, and copayments, with no difference in premiums. These reductions are in addition to tax credits that help reduce your monthly premiums. If you qualify for CSRs, you will qualify for one of three levels of CSR plans (73, 87, or 94), depending on your income and family size.

By selecting a CSR plan, you will pay the same premium per month as a regular Silver plan, but you will pay less for copayments, deductibles, and coinsurance when you see the doctor, go to the hospital or get a prescription. These reduced amounts are shown in this document for each HealthSource RI plan. You may qualify based on your family size and how your income compares to the Federal Poverty Level (FPL):

Metal Level	Silve	er 73		Silver 87		Silver 94				
Percentage of the Federal Poverty Level (FPL)	200% FPL	250% FPL		150% FPL 200% FPL			100% FPL	150% FPL		
		ualify if your between:		You may qualify if your income is between:						alify if your between:
Family Size 1	\$23,540	\$29,475		\$17,655	\$23,540		\$11,770	\$17,655		
2	\$31,860	\$39,825		\$23,895	\$31,860		\$15,930	\$23,895		
3	\$40,180	\$50,225		\$30,135	\$40,180		\$20,090	\$30,135		
4	\$48,500	\$60,625		\$36,375	\$48,500		\$24,250	\$36,375		
5	\$56,820	\$71,025		\$42,615	\$56,820		\$28,410	\$42,615		
6	\$65,140	\$81,425		\$48,855	\$65,140		\$32,570	\$48,855		

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 HealthSourceRI.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,W-F 8:30am-5pm, Tues 8:30am-7pm

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

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).

¹ 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.

² A modified variation of this plan that excludes coverage for most abortions is also available. "Modified" in the plan name indicates the modified variation.

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Rates as of December 1, 2015. This is a partial summary of benefits and coverage and should not be considered a contract. This information, including all quoted rates, should be used for informational purposes only. Changes may be made to the benefits and coverage policies described here. You should only rely upon the Evidence of Coverage document provided to you from your health insurance company for information about covered benefits, limitations and exclusions.

Individual Premiums:	Insurance Company	BCBSRI	BCBSRI	BCBSRI	BCBSRI
A premium is the amount you must pay each month	Plan Name	*BlueSolutions for HSA Direct (CSR73)	VantageBlue Direct Plan (CSR73)	BasicBlue Direct (CSR73)	BlueCHiP Direct WPD (CSR73)
for health insurance. Premiums vary by age and family size, and you may qualify for tax credits if you earn less	Plan Income Range % of Federal Poverty Level (FLP)	200-250% FPL	200-250% FPL	200-250% FPL	200-250% FPL
than \$47,080 for an individual or \$97,000 for a family of four.	Metal Level	SILVER 73	SILVER 73	SILVER 73	SILVER 73
Health Savings Accounts (HSAs) A Health Savings Account-qualified plan allows you to	Monthly Premium (21-year old) Before tax credit	\$213	\$263	\$218	\$206
contribute to a separate tax-exempt account which can be used for health care expenses like deductibles	Monthly Premium (40-year old) Before tax credit	\$273	\$336	\$279	\$263
and copayments.	Monthly Premium (60-year old) Before tax credit	\$579	\$713	\$592	\$558
	HSA Qualified				
HOW YOU GET YOUR CARE Some insurers offer plans that include a smaller number	Plan Type (see definitions on reverse)	PPO	PPO	PPO	POS
of providers that the insurers have decided offer high-quality care at a lower cost. Plans have different	Referral Required	No	No	No	Yes
monthly premiums and out-of-pocket costs for care, as well as different providers (like doctors and hospitals)	Network Coverage Area	National	National	National	RI only
you can visit. The providers included in a plan's network — and how those providers are paid for the care they give you — helps determine how much you will pay for your health insurance plan. Some plans assign levels ("tiers") to doctors and hospitals within their networks, and you may pay less to see providers in certain tiers When choosing a plan, you should consider the monthly	RI Provider Information (subject to change)	1,234 PCPs/ pediatricians 4,244 specialists 15 of 15 hospitals 582 dentists	1,234 PCPs/ pediatricians 4,244 specialists 15 of 15 hospitals 582 dentists	1,234 PCPs/ pediatricians 4,244 specialists 15 of 15 hospitals 582 dentists	1,234 PCPs/ pediatricians 4,244 specialists 15 of 15 hospitals 582 dentists
premium, as well as any out-of-pocket costs, providers you prefer to visit, prescription drugs you take, and any other health care needs you have. All plans cover preventive health care services at no cost.	Out of Network Coverage, Non-Emergency	Yes – 30% Coinsurance	Yes— 40% Coinsurance	Not covered except for urgent or emergent care	Not covered except for urgent or emergent care
MAXIMUM OUT-OF-POCKET In addition to your monthly premium, the maximum out-of-pocket amount is the most you could have to pay in deduct- ibles, copayments and coinsurance during the year.	Maximum Out-Of-Pocket (MOOP) Medical + Drug	\$3,500 Individual \$7,000 Family	\$5,000 Individual \$10,000 Family	\$5,200 Individual \$10,400 Family	\$5,200 Individual \$10,400 Family
DEDUCTIBLES The deductible is the amount you must pay out-of-pocket for certain health care services before your insurance plan begins to pay. The deductible amount is in addition to your monthly premium. Services subject to the	Deductible - Medical	\$2,200 Individual \$4,400 Family	\$2,700 Individual \$5,400 Family	\$2,900 Individual \$5,800 Family	\$2,100 Individual \$4,200 Family
deductible vary by plan and may include doctor visits and hospitals stays, as well as prescription medications.	Deductible - Drug	Combined with Medical	\$0	Only Tiers 3, 4, and 5 apply to deductible	Only Tiers 3, 4, and 5 apply to deductible
COPAYMENTS & COINSURANCE	Primary Care	10%	First sick visit free, all other visits \$20 PCMH; \$40 Non-PCMH	\$10 PCMH; \$20 Non-PCMH	\$30 PCMH; \$50 Non-PCMH
Copayments are fixed dollar amounts that you must pay for certain types of health care services	Specialist Visit	10%	\$55	\$45	\$60
each time you use them.	Preventative Care	\$0	\$0	\$0	\$ 0
Coinsurance is a percentage of the total cost of			φõ	φυ	\$0
certain types of health care services that you must pay. Coinsurance usually applies after you meet	Urgent Care	10%	\$75	\$75	\$0 \$75
certain types of health care services that you must pay. Coinsurance usually applies after you meet your deductible.	Urgent Care ER Services			• -	• •
certain types of health care services that you must pay. Coinsurance usually applies after you meet		10%	\$75	\$75	\$75
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	ER Services	10%	\$75 \$200	\$75 10%	\$75 10%
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	ER Services Inpatient Hospital X-rays & other Diag. Imaging High End Imaging: CT/PET/MRI	10% 10% 10%	\$75 \$200 20%	\$75 10% 10%	\$75 10% 10%
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	ER Services Inpatient Hospital X-rays & other Diag. Imaging High End Imaging: CT/PET/MRI Mental Health/Substance Abuse - Office Visits	10% 10% 10% 10%	\$75 \$200 20% 20%	\$75 10% 10% 10%	\$75 10% 10% 10%
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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	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	10% 10% 10% 10% 10% 10%	\$75 \$200 20% 20% 20% \$55 20%	\$75 10% 10% 10% \$45 10%	\$75 10% 10% 10% \$60 10%
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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	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	10% 10% 10% 10% 10% 10% 10% 10%	\$75 \$200 20% 20% 20% \$55 20% 20% 20%	\$75 10% 10% 10% \$45 10% 10% 10%	\$75 10% 10% 10% \$60 10% 10% 10%
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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 PCMIH provider may cost less in certain plans.	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	10% 10% 10% 10% 10% 10% 10% 10% 10% Yes \$10	\$75 \$200 20% 20% 20% \$55 20% 20% 20% 20% 20% 20% 20% 20% 20% 20%	\$75 10% 10% 10% \$45 10% 10% 10% 10% Yes \$10	\$75 10% 10% 10% \$60 10% 10% 10% 10% Yes \$10
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Insurance Company	NHPRI	NHPRI	UHC	UHC	UHC
Plan Name	Neighborhood Community (CSR73)	*Neighborhood Value (CSR73)	Silver Compass HSA 2100 (CSR73)	Silver Compass 2500 (CSR73)	Silver Choice 1900 (CSR73) ²
Plan Income Range % of Federal Poverty Level (FLP)	200-250% FPL				
Metal Level	SILVER 73				
Monthly Premium (21-year old) Before tax credit	\$203	\$217	\$213	\$237	\$250
Monthly Premium (40-year old) Before tax credit	\$259	\$277	\$273	\$303	\$320
Monthly Premium (60-year old) Before tax credit	\$550	\$589	\$579	\$644	\$679
HSA Qualified					
Plan Type (see definitions on reverse)	НМО	НМО	НМО	НМО	НМО
Referral Required	No	No	Yes	Yes	No
Network Coverage Area	RI only	RI only	RI only	RI only	National
RI Provider Information (subject to change)	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	1,076 PCPs/ pediatricians 4,711 specialists 14 of 15 hospitals	1,304 PCPs/ pediatricians 5,321 specialists 15 of 15 hospitals
Out of Network Coverage, Non-Emergency	Not covered except for urgent or emergent care				
Maximum Out-Of-Pocket (MOOP) Medical + Drug	\$4,000 Individual \$8,000 Family	\$5,200 Individual \$10,400 Family	\$5,450 Individual \$6,850 Family	\$5,450 Individual \$10,900 Family	\$5,450 Individual \$10,900 Family
Deductible - Medical	\$2,150 Individual \$4,300 Family	\$3,000 Individual \$6,000 Family	\$2,100 Individual \$5,250 Family	\$2,500 Individual \$5,000 Family	\$1,900 Individual \$3,800 Family
Deductible - Drug	Combined with Medical	\$0	Combined with Medical	\$0	\$0
Primary Care	10%	\$10	\$35	\$30	\$35
Specialist Visit	10%	\$40	\$70	\$60	\$70
Preventative Care	\$0	\$0	\$0	\$0	\$0
Urgent Care	10%	\$40	\$75	\$100	\$75
ER Services	10%	\$200	\$150	\$200	20%
Inpatient Hospital	10%	10%	\$500 per inpatient stay	20%	20%
X-rays & other Diag. Imaging	10%	10%	0%	20%	20%
High End Imaging: CT/PET/MRI	10%	10%	\$150 Tier 1; \$250 Tier 2	20%	20% Tier 1; \$250 in add- ition to deductible ¹ Tier 2
Mental Health/Substance Abuse - Office Visits	10%	\$10	\$70	\$60	\$70
Speech/Occup/Phys Therapy, Outpatient Rehab	10%	\$40	0%	20%	20%
Lab Services, Outpatient	10%	10%	0%	20%	20%
Skilled Nursing Facility	10%	10%	\$500 per inpatient stay	20%	20%
Outpatient Surgery/Services	10%	10%	\$150 Tier 1; \$250 Tier 2	20%	20% Tier 1; \$250 in add- ition to deductible ¹ Tier 2
Pediatric Dental Coverage	No	No	Yes	Yes	Yes
Tier 1	\$10	\$15	\$15	\$15	\$15
Tier 2	\$35	\$40	\$40	\$40	\$40
Tier 3	\$60	\$90	\$70	\$70	\$70
Tier 4	\$100	\$200	\$100	\$100	\$100

BCBSRI: Blue Cross & Blue Shield of Rhode Island • NHPRI: Neighborhood Health Plan of Rhode Island • UHC: UnitedHealthcare

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BASIC PLAN INFORMATION	Insurance Company	BCBSRI	BCBSRI	BCBSRI	BCBSRI
Individual Premiums: A premium is the amount you must pay each month	Plan Name	*BlueSolutions for HSA Direct (CSR87)	VantageBlue Direct Plan (CSR87)	BasicBlue Direct (CSR87)	WE ^W BlueCHiP Direct WPD (CSR87)
for health insurance. Premiums vary by age and family size, and you may qualify for tax credits if you earn less	Plan Income Range % of Federal Poverty Level (FLP)	150-200% FPL	150-200% FPL	150-200% FPL	150-200% FPL
than \$47,080 for an individual or \$97,000 for a family of four.	Metal Level	SILVER 87	SILVER 87	SILVER 87	SILVER 87
Health Savings Accounts (HSAs) A Health Savings Account-qualified plan allows you to	Monthly Premium (21-year old) Before tax credit	\$213	\$263	\$218	\$206
contribute to a separate tax-exempt account which can be used for health care expenses like deductibles	Monthly Premium (40-year old) Before tax credit	\$273	\$336	\$279	\$263
and copayments.	Monthly Premium (60-year old) Before tax credit	\$579	\$713	\$592	\$558
	HSA Qualified				
HOW YOU GET YOUR CARE Some insurers offer plans that include a smaller number	Plan Type (see definitions on reverse)	PPO	PPO	PPO	POS
of providers that the insurers have decided offer high-quality care at a lower cost. Plans have different	Referral Required	No	No	No	Yes
monthly premiums and out-of-pocket costs for care, as well as different providers (like doctors and hospitals)	Network Coverage Area	National	National	National	RI only
you can visit. The providers included in a plan's network — and how those providers are paid for the care they give you — helps determine how much you will pay for your health insurance plan. Some plans assign levels ("tiers") to doctors and hospitals within their networks, and you may pay less to see providers in certain tiers When choosing a plan, you should consider the monthly	RI Provider Information (subject to change)	1,234 PCPs/ pediatricians 4,244 specialists 15 of 15 hospitals 582 dentists	1,234 PCPs/ pediatricians 4,244 specialists 15 of 15 hospitals 582 dentists	1,234 PCPs/ pediatricians 4,244 specialists 15 of 15 hospitals 582 dentists	1,234 PCPs/ pediatricians 4,244 specialists 15 of 15 hospitals 582 dentists
premium, as well as any out-of-pocket costs, providers you prefer to visit, prescription drugs you take, and any other health care needs you have. All plans cover preventive health care services at no cost.	Out of Network Coverage, Non-Emergency	Yes— 30% Coinsurance	Yes – 40% Coinsurance	Not covered except for urgent or emergent care	Not covered except for urgent or emergent care
MAXIMUM OUT-OF-POCKET In addition to your monthly premium, the maximum out-of-pocket amount is the most you could have to pay in deduct- ibles, copayments and coinsurance during the year.	Maximum Out-Of-Pocket (MOOP) Medical + Drug	\$1,750 Individual \$3,500 Family	\$2,000 Individual \$4,000 Family	\$2,250 Individual \$4,500 Family	\$2,000 Individual \$4,000 Family
DEDUCTIBLES The deductible is the amount you must pay out-of-pocket for certain health care services before your insurance plan begins to pay. The deductible amount is in addition to your monithly premium. Services subject to the	Deductible - Medical	\$300 Individual \$600 Family	\$150 Individual \$300 Family	\$250 Individual \$500 Family	\$350 Individual \$700 Family
deductible vary by plan and may include doctor visits and hospitals stays, as well as prescription medications.	Deductible - Drug	Combined with Medical	\$0	Only Tiers 3, 4, and 5 apply to deductible	Only Tiers 3, 4, and 5 apply to deductible
COPAYMENTS & COINSURANCE	Primary Care		First sick visit free, all other visits \$20 PCMH; \$40 Non-PCMH	\$10 PCMH; \$20 Non-PCMH	\$10 PCMH; \$20 Non-PCMH
Copayments are fixed dollar amounts that you must pay for certain types of health care services	Specialist Visit	10%	\$55	\$30	\$25
and time you use them					
each time you use them. Coinsurance is a percentage of the total cost of	Preventative Care	\$0	\$0	\$0	\$0
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	•	\$0 10%	\$0 \$75	\$0 \$75	\$0 \$75
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.	Preventative Care			* -	• -
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	Preventative Care Urgent Care	10%	\$75	\$75	\$75
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	Preventative Care Urgent Care ER Services	10%	\$75 \$200	\$75 10%	\$75
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	Preventative Care Urgent Care ER Services Inpatient Hospital X-rays & other Diag. Imaging High End Imaging: CT/PET/MRI	10% 10% 10%	\$75 \$200 20%	\$75 10% 10%	\$75 10% 10%
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	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	10% 10% 10% 10%	\$75 \$200 20% 20%	\$75 10% 10% 10%	\$75 10% 10% 10%
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	Preventative Care Urgent Care ER Services Inpatient Hospital X-rays & other Diag. Imaging High End Imaging: CT/PET/MRI Mental Health/Substance Abuse	10% 10% 10% 10% 10%	\$75 \$200 20% 20% 20%	\$75 10% 10% 10% 10%	\$75 10% 10% 10% 10%
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	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,	10% 10% 10% 10% 10%	\$75 \$200 20% 20% 20% \$55	\$75 10% 10% 10% 10% \$30	\$75 10% 10% 10% 10% \$25
 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 	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	10% 10% 10% 10% 10% 10%	\$75 \$200 20% 20% 20% \$55 20%	\$75 10% 10% 10% \$30 10%	\$75 10% 10% 10% \$25 10%
 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 	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	10% 10% 10% 10% 10% 10% 10%	\$75 \$200 20% 20% 20% \$55 20% 20%	\$75 10% 10% 10% \$30 \$30 10% 10%	\$75 10% 10% 10% \$25 10% 10%
 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 	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	10% 10% 10% 10% 10% 10% 10% 10%	\$75 \$200 20% 20% 20% \$55 20% 20% 20%	\$75 10% 10% 10% \$30 10% 10% 10%	\$75 10% 10% 10% \$25 10% 10% 10%
<text><text><text><text><text></text></text></text></text></text>	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	10% 10% 10% 10% 10% 10% 10% 10% 10%	\$75 \$200 20% 20% 20% \$55 20% 20% 20% 20%	\$75 10% 10% 10% \$30 10% 10% 10% 10%	\$75 10% 10% 10% \$25 10% 10% 10% 10%
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 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.	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	10% 10% 10% 10% 10% 10% 10% 10% 10% 10%	\$75 \$200 20% 20% 20% \$55 20% 20% 20% 20% 20% 20% Yes	\$75 10% 10% 10% \$30 10% 10% 10% 10% Yes	\$75 10% 10% 10% \$25 10% 10% 10% 10% Yes
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 sources and the dollar amount or percentage sources and the atter and the after are providers that work together to coordinate your care. Visiting a PCMH provider may cost less in certain plans.	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	10% 10% 10% 10% 10% 10% 10% 10% 10% Yes \$10	\$75 \$200 20% 20% 20% \$55 20% 20% 20% 20% 20% 20% 20% 20% 20%	\$75 10% 10% 10% \$30 \$30 10% 10% 10% 10% Yes \$10	\$75 10% 10% 10% \$25 10% 10% 10% 10% Yes \$10
 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 amount. After that, 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. 	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	10% 10% 10% 10% 10% 10% 10% 10% 10% 10%	\$75 \$200 20% 20% 20% 20% 20% 20% 20% 20% 20%	\$75 10% 10% 10% \$30 \$30 10% 10% 10% 10% \$30 \$10 \$30	\$75 10% 10% 10% \$25 10% 10% 10% 10% 10% \$25 \$10 \$20

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Rates as of December 1, 2015. This is a partial summary of benefits and coverage and should not be considered a contract. This information, including all quoted rates, should be used for informational purposes only. Changes may be made to the benefits and coverage policies described here. You should only rely upon the Evidence of Coverage document provided to you from your health insurance company for information about covered benefits, limitations and exclusions.

Insurance Company	NHPRI	NHPRI	UHC	UHC	UHC
Plan Name	Neighborhood Community (CSR87)	*Neighborhood Value (CSR87)	Silver Compass HSA 500 (CSR87)	Silver Compass 500 (CSR87)	Silver Choice 500 (CSR87) ²
Plan Income Range % of Federal Poverty Level (FLP)	150-200% FPL	150-200% FPL	150-200% FPL	150-200% FPL	150-200% FPL
Metal Level	SILVER 87	SILVER 87	SILVER 87	SILVER 87	SILVER 87
Monthly Premium (21-year old) Before tax credit	\$203	\$217	\$213	\$237	\$250
Monthly Premium (40-year old) Before tax credit	\$259	\$277	\$273	\$303	\$320
Monthly Premium (60-year old) Before tax credit	\$550	\$589	\$579	\$644	\$679
HSA Qualified					
Plan Type (see definitions on reverse)	НМО	НМО	НМО	НМО	НМО
Referral Required	No	No	Yes	Yes	No
Network Coverage Area	RI only	RI only	RI only	RI only	National
RI Provider Information (subject to change)	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	1,076 PCPs/ pediatricians 4,711 specialists 14 of 15 hospitals	1,304 PCPs/ pediatricians 5,321 specialists 15 of 15 hospitals
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	\$2,250 Individual \$4,500 Family	\$2,250 Individual \$4,500 Family	\$1,500 Individual \$3,000 Family	\$1,500 Individual \$3,000 Family	\$1,500 Individual \$3,000 Family
Deductible - Medical	\$500 Individual \$1,000 Family	\$500 Individual \$1,000 Family	\$500 Individual \$1,000 Family	\$500 Individual \$1,000 Family	\$500 Individual \$1,000 Family
Deductible - Drug	Combined with Medical	\$0	Combined with Medical	\$0	\$0
Primary Care	10%	\$10	\$35	\$30	\$35
Specialist Visit	10%	\$20	\$70	\$60	\$70
Preventative Care	\$0	\$0	\$0	\$0	\$0
Urgent Care	10%	\$20			
ER Services		\$20	\$75	\$100	\$75
Inpatient Hospital	10%	\$100	\$75 \$150	\$100 \$200	\$75
· · ·	10%			 	
X-rays & other Diag. Imaging		\$100	\$150 \$500 per	\$200	20%
· · ·	10%	\$100 10%	\$150 \$500 per inpatient stay	\$200 20%	20% 20%
X-rays & other Diag. Imaging High End Imaging: CT/PET/MRI Mental Health/Substance Abuse	10% 10%	\$100 10% 10%	\$150 \$500 per inpatient stay 0% \$150 Tier 1;	\$200 20% 20%	20% 20% 20% 20% Tier 1; \$250 in add-
X-rays & other Diag. Imaging High End Imaging: CT/PET/MRI Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy,	10% 10% 10%	\$100 10% 10% 10%	\$150 \$500 per inpatient stay 0% \$150 Tier 1; \$250 Tier 2	\$200 20% 20% 20%	20% 20% 20% 20% Iier 1; \$250 in add- ition to deductible ¹ Tier 2
X-rays & other Diag. Imaging High End Imaging: CT/PET/MRI Mental Health/Substance Abuse - Office Visits	10% 10% 10% 10%	\$100 10% 10% 10% \$10	\$150 \$500 per inpatient stay 0% \$150 Tier 1; \$250 Tier 2 \$70	\$200 20% 20% 20% \$60	20% 20% 20% 20% 20% Tier 1; \$250 in add- ition to deductible' Tier 2 \$70
X-rays & other Diag. Imaging High End Imaging: CT/PET/MRI Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab	10% 10% 10% 10%	\$100 10% 10% 10% \$10 \$20	\$150 \$500 per inpatient stay 0% \$150 Tier 1; \$250 Tier 2 \$70 0%	\$200 20% 20% 20% \$60 20%	20% 20% 20% 20% 70% 20% Tier 1; \$250 in add- ition to deductible' Tier 2 \$70 20%
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	10% 10% 10% 10% 10%	\$100 10% 10% \$10 \$10 \$20 10%	\$150 \$500 per inpatient stay 0% \$150 Tier 1; \$250 Tier 2 \$70 0% 0% 0% \$500 per	\$200 20% 20% 20% \$60 20% 20%	20% 20% 20% 20% Tier 1; \$250 in add- ition to deductible' Tier 2 \$70 20% 20%
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	10% 10% 10% 10% 10% 10%	\$100 10% 10% \$10 \$10 \$20 10% 10%	\$150 \$500 per inpatient stay 0% \$150 Tier 1; \$250 Tier 2 \$70 0% 0% 0% \$500 per inpatient stay \$150 Tier 1;	\$200 20% 20% 20% \$60 20% 20% 20%	20% 20% 20% 20% 70% 20% 20% 20% 20% 20% 20% Tier 1; \$250 in add-
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	10% 10% 10% 10% 10% 10% 10%	\$100 10% 10% \$10 \$10 \$20 10% 10%	\$150 \$500 per inpatient stay 0% \$150 Tier 1; \$250 Tier 2 \$70 0% 0% 0% \$500 per inpatient stay \$150 Tier 1; \$250 Tier 2	\$200 20% 20% 20% \$60 20% 20% 20% 20%	20% 20% 20% 20% Tier 1; \$250 in add- ition to deductible' Tier 2 \$70 20% 20% 20% 20% 20% Tier 1; \$250 in add- ition to deductible' Tier 2
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	10% 10% 10% 10% 10% 10% 10% 10% No	\$100 10% 10% \$10 \$10 \$20 10% 10% 10% No	\$150 \$500 per inpatient stay 0% \$150 Tier 1; \$250 Tier 2 \$70 0% 0% 0% \$500 per inpatient stay \$500 per inpatient stay \$250 Tier 2 Yes	\$200 20% 20% 20% \$60 20% 20% 20% 20% 20% Yes	20% 20% 20% 20% 20% 20% 20% 20% 20% 20%
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	10% 10% 10% 10% 10% 10% 10% 10% No \$7	\$100 10% 10% \$10 \$10 \$20 10% 10% 10% No \$10	\$150 \$500 per inpatient stay 0% \$150 Tier 1; \$250 Tier 2 \$70 0% 0% 0% \$500 per inpatient stay \$150 Tier 1; \$250 Tier 2 Yes \$15	\$200 20% 20% 20% \$60 20% 20% 20% 20% 20% 20% 20% 20% 20% 20	20% 20% 20% 20% Tier 1; \$250 in add ition to deductible' Tier 2 \$70 20% 20% 20% 20% 1er 1; \$250 in add- ition to deductible' Tier 2 Yes \$15
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	10% 10% 10% 10% 10% 10% 10% 10% 57 \$30	\$100 10% 10% \$10 \$20 10% 10% 10% 10% \$10 \$10 \$35	\$150 \$500 per inpatient stay 0% \$150 Tier 1; \$250 Tier 2 \$70 0% 0% 0% \$500 per inpatient stay \$150 Tier 1; \$250 Tier 2 Yes \$15 \$40	\$200 20% 20% 20% \$60 20% 20% 20% 20% 20% 20% \$15 \$15 \$40	20% 20% 20% 20% 20% 1ier 1; \$250 in add- ition to deductible' Tier 2 20% 20% 20% 20% 20% 20% 20% 20% 20% 2

BCBSRI: Blue Cross & Blue Shield of Rhode Island • NHPRI: Neighborhood Health Plan of Rhode Island • UHC: UnitedHealthcare

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BASIC PLAN INFORMATION	Insurance Company	BCBSRI	BCBSRI	BCBSRI	BCBSRI
Individual Premiums: A premium is the amount you must pay each month	Plan Name	*BlueSolutions for HSA Direct (CSR94)	VantageBlue Direct Plan (CSR94)	MEN BasicBlue Direct (CSR94)	BlueCHiP Direct WPD (CSR94)
for health insurance. Premiums vary by age and family size, and you may qualify for tax credits if you earn less	Plan Income Range % of Federal Poverty Level (FLP)	100-150% FPL	100-150% FPL	100-150% FPL	100-150% FPL
than \$47,080 for an individual or \$97,000 for a family of four.	Metal Level	SILVER 94	SILVER 94	SILVER 94	SILVER 94
Health Savings Accounts (HSAs) A Health Savings Account-qualified plan allows you to	Monthly Premium (21-year old) Before tax credit	\$213	\$263	\$218	\$206
contribute to a separate tax-exempt account which can be used for health care expenses like deductibles	Monthly Premium (40-year old) Before tax credit	\$273	\$336	\$279	\$263
and copayments.	Monthly Premium (60-year old) Before tax credit	\$579	\$713	\$592	\$558
	HSA Qualified				
HOW YOU GET YOUR CARE Some insurers offer plans that include a smaller number	Plan Type (see definitions on reverse)	PPO	PPO	PPO	POS
of providers that the insurers have decided offer high-quality care at a lower cost. Plans have different	Referral Required	No	No	No	Yes
monthly premiums and out-of-pocket costs for care, as well as different providers (like doctors and hospitals)	Network Coverage Area	National	National	National	RI only
you can visit. The providers included in a plan's network – and how those providers are paid for the care they give you – helps determine how much you will pay for your health insurance plan. Some plans assign levels ("tiers") to doctors and hospitals within their networks, and you may pay less to see providers in certain tiers When choosing a plan, you should consider the monthly	RI Provider Information (subject to change)	1,234 PCPs/ pediatricians 4,244 specialists 15 of 15 hospitals 582 dentists			
premium, as well as any out-of-pocket costs, providers you prefer to visit, prescription drugs you take, and any other health care needs you have. All plans cover preventive health care services at no cost.	Out of Network Coverage, Non-Emergency	Yes – 30% Coinsurance	Yes— 40% Coinsurance	Not covered except for urgent or emergent care	Not covered except for urgent or emergent care
MAXIMUM OUT-OF-POCKET In addition to your monthly premium, the maximum out-of-pocket amount is the most you could have to pay in deduct- ibles, copayments and coinsurance during the year.	Maximum Out-Of-Pocket (MOOP) Medical + Drug	\$750 Individual \$1,500 Family	\$725 Individual \$1,450 Family	\$750 Individual \$1,500 Family	\$650 Individual \$1,300 Family
DEDUCTIBLES The deductible is the amount you must pay out-of-pocket for certain health care services before your insurance plan begins to pay. The deductible amount is in addition to your monthly premium. Services subject to the	Deductible - Medical	\$0	\$0	\$0	\$0
deductible vary by plan and may include doctor visits and hospitals stays, as well as prescription medications.	Deductible - Drug	\$0	\$0	\$0	\$0
COPAYMENTS & COINSURANCE	Primary Care	10%	First sick visit free, all other visits \$20 PCMH; \$40 Non-PCMH	\$5 PCMH; \$15 Non-PCMH	\$5 PCMH; \$15 Non-PCMH
Copayments are fixed dollar amounts that you must pay for certain types of health care services	Specialist Visit	10%	\$55	\$20	\$20
each time you use them. Coinsurance is a percentage of the total cost of	Preventative Care	\$0	\$0	\$0	\$0
certain types of health care services that you must pay. Coinsurance usually applies after you meet	Urgent Care	10%	\$75	\$75	\$75
your deductible. In TIERED plans, copayments or coinsurance for	ER Services	10%	\$200	10%	10%
a particular service may vary depending on your choice of health provider.	Inpatient Hospital	10%	20%	10%	10%
The WHITE area is not subject to the deductible. It	X-rays & other Diag. Imaging	10%	20%	10%	10%
is the dollar amount or percentage you hav her visit	A-rays & other blag. Inaging	10 %	20 /0		10 /0
is the dollar amount or percentage you pay per visit or health care service, regardless of whether you have met your deductible	High End Imaging: CT/PET/MRI	10%	20%	10%	10%
or health care service, regardless of whether you have met your deductible. The SHADED area is subject to the deductible. You	High End Imaging: CT/PET/MRI Mental Health/Substance Abuse - Office Visits				
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	High End Imaging: CT/PET/MRI Mental Health/Substance Abuse	10%	20%	10%	10%
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	High End Imaging: CT/PET/MRI Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy,	10% 10%	20% \$55	10% \$20	10% \$20
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	High End Imaging: CT/PET/MRI Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab	10% 10% 10%	20% \$55 20%	10% \$20 10%	10% \$20 10%
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	High End Imaging: CT/PET/MRI Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab Lab Services, Outpatient	10% 10% 10% 10%	20% \$55 20% 20%	10% \$20 10% 10%	10% \$20 10% 10%
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	High End Imaging: CT/PET/MRI Mental Health/Substance Abuse - Office Visits Speech/Occup/Phys Therapy, Outpatient Rehab Lab Services, Outpatient Skilled Nursing Facility	10% 10% 10% 10% 10%	20% \$55 20% 20% 20%	10% \$20 10% 10%	10% \$20 10% 10%
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	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	10% 10% 10% 10% 10%	20% \$55 20% 20% 20% 20%	10% \$20 10% 10% 10%	10% \$20 10% 10% 10%
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."	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	10% 10% 10% 10% 10% 10% Yes	20% \$55 20% 20% 20% 20% 20% Yes	10% \$20 10% 10% 10% 10% Yes	10% \$20 10% 10% 10% 10% Yes
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	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	10% 10% 10% 10% 10% Yes \$10	20% \$55 20% 20% 20% 20% Yes \$10	10% \$20 10% 10% 10% Yes \$10	10% \$20 10% 10% 10% Yes \$5
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.	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	10% 10% 10% 10% 10% Yes \$10 \$30	20% \$55 20% 20% 20% 20% Yes \$10 \$35	10% \$20 10% 10% 10% Yes \$10 \$30	10% \$20 10% 10% 10% 10% Yes \$5 \$5 \$15

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.



Rates as of December 1, 2015. This is a partial summary of benefits and coverage and should not be considered a contract. This information, including all quoted rates, should be used for informational purposes only. Changes may be made to the benefits and coverage policies described here. You should only rely upon the Evidence of Coverage document provided to you from your health insurance company for information about covered benefits, limitations and exclusions.

Plan Name Designation Weighborhood (Community) Billion Compass (Subset)	Insurance Company	NHPRI	NHPRI	UHC	UHC	UHC
Plan Income Range wir Astend Power 100-150% FPL 100 <fd< th=""> 100<fd< th=""> 100<fd< th=""> 100<fd< th=""> 100<fd< th=""> 100<fd< th=""> <</fd<></fd<></fd<></fd<></fd<></fd<>	Plan Name					
Metal Level SILVER 94 SIZO Monthly Premium (60-year old) SS00 S669 S579 S044 S879 Monthly Premium (60-year old) S000 S000 Net Stopper or set Net Stopper or set Net Stopper or set Net Net Net Net Net Net Net Net Net Net <t< td=""><td>Plan Income Range</td><td></td><td></td><td></td><td></td><td></td></t<>	Plan Income Range					
Baters is coals Baters Baters Baters Baters Baters Baters Baters Baters Baters Basers Basers <thbasers< th=""> <th< td=""><td></td><td>SILVER 94</td><td>SILVER 94</td><td>SILVER 94</td><td>SILVER 94</td><td>SILVER 94</td></th<></thbasers<>		SILVER 94	SILVER 94	SILVER 94	SILVER 94	SILVER 94
Monthly Promium (40-year old) 9259 9277 9273 9303 9320 Monthly Premium (60-year old) 5500 5569 5669 5679 5644 5679 HSA Qualified Monthly Premium (60-year old) 5500 5689 5679 5644 5679 Plan Type (see definitions on revens) HMO HMO HMO HMO HMO HMO Referral Required No No Yes No Yes No RI Provider Information (exigen vector) 1.364 PCPar 1.375 PCPar 1.376 PCPar		\$203	\$217	\$213	\$237	\$250
Monthly Premium (60-year old) Before the coefficient according (Born tak coefficient according) SSS0 SS00		\$259	\$277	\$273	\$303	\$320
HSA Qualified HMO <	Monthly Premium (60-year old)	\$550	\$589	\$579	\$644	\$679
Referral Required No No Yes Yes No Network Coverage Area Ri only National RI Provider Information (adject to change) 1,384 PCPat/ (adject to change) 1,401 Fospitals 1,401 Fospitals 1,304 PCPat/ (adject to change) 1,401 Fospitals 1,401 Fosp						
Network Coverage Area Fl only Fl only </td <td>Plan Type (see definitions on reverse)</td> <td>НМО</td> <td>НМО</td> <td>НМО</td> <td>НМО</td> <td>НМО</td>	Plan Type (see definitions on reverse)	НМО	НМО	НМО	НМО	НМО
RI Provider Information (subject to change) 1.364 PCPa/ pediatricians 5.00 specialists 1.076 PCPa/ pediatricians 5.00 specialists 1.076 PCPa/ pediatricians 5.00 specialists 1.076 PCPa/ pediatricians 4.711 specialisticalists 1.304 PCPa/ pediatricians 4.711 specialisticalists 1.304 PCPa/ solution	Referral Required	No	No	Yes	Yes	No
gediatricians (subject to change) pediatricians (stablect to change) pediatricians (stable specialisis 15 of 15 hospitals pediatricians 4,71 specialisis 14 of 15 hospitals pediatricians 4,71 specialisis 14 of 15 hospitals pediatricians 4,71 specialisis 15 of 15 hospitals pediatricians 5,21 specialisis 0 comptor upped or emprovement or emp	Network Coverage Area	RI only	RI only	RI only	RI only	National
On On Herwork Correlater, or emergent careexcept for urgent or emergent careexcept for urgent stood familyStood familySt		pediatricians 5,808 specialists	pediatricians 5,808 specialists	pediatricians 4,711 specialists	pediatricians 4,711 specialists	pediatricians 5,321 specialists
(MOOP) Medical + Drug S2,000 Family S3,000 Family S2,000 Family S1,000 Family <ths< td=""><td></td><td>except for urgent</td><td>except for urgent</td><td>except for urgent</td><td>except for urgent</td><td>except for urgent</td></ths<>		except for urgent	except for urgent	except for urgent	except for urgent	except for urgent
Deductible - Drug S0 S0 S0 S0 S0 Primary Care 10% \$5 \$35 \$30 \$35 Specialist Visit 10% \$15 \$70 \$60 \$70 Preventative Care \$0 \$0 \$0 \$0 \$0 \$0 Urgent Care 10% \$15 \$75 \$100 \$75 ER Services 10% \$50 \$150 \$200 20% Inpatient Hospital 10% 10% \$500 per inpatient stay 20% 20% X-rays & other Diag. Imaging 10% 10% \$500 per inpatient stay 20% 20% K-rays & other Diag. Imaging 10% 10% \$500 per inpatient stay 20%						
Primary Care 10% S5 S35 S30 S35 Specialist Visit 10% S15 S70 S60 S70 Preventative Care S0 S0 S0 S0 S0 S0 Urgent Care 10% S15 S75 S100 S75 ER Services 10% S50 S150 S200 20% Inpatient Hospital 10% 10% S500 per inpatient stay 20% 20% X-rays & other Diag. Imaging 10% 10% S0 20% 20% High End Imaging: CT/PET/MRI 10% 10% S15 S0 20% 20% Mental Health/Substance Abuse 10% S15 S0 20%	Deductible - Medical	\$0	\$0	\$0	\$0	\$0
Specialist Visit 10% \$15 \$70 \$60 \$70 Preventative Care \$0 \$0 \$0 \$0 \$0 \$0 Urgent Care 10% \$15 \$75 \$100 \$75 ER Services 10% \$50 \$150 \$200 20% Inpatient Hospital 10% 10% \$500 per inpatient stay 20% 20% X-rays & other Diag. Imaging 10% 10% \$50 \$150 \$200 20% High End Imaging: CT/PET/MRI 10% 10% \$100 \$100 \$20% 20% 20% Mental Health/Substance Abuse 10% \$55 \$70 \$60 \$70 Speech/Cocup/Phys Therapy, 10% \$15 \$0 20% 20% Outpatient Rehab 10% 10% \$500 per inpatient stay 20% 20% Skilled Nursing Facility 10% 10% \$500 per inpatient stay 20% 20% Outpatient Surgery/Services 10% 10% \$2500	Deductible - Drug	\$0	\$0	\$0	\$0	\$0
Preventative Care S0 S0 S0 S0 S0 Urgent Care 10% \$15 \$75 \$100 \$75 ER Services 10% \$50 \$150 \$200 20% Inpatient Hospital 10% 10% \$500 per impatient stay 20% 20% X-rays & other Diag. Imaging 10% 10% \$0 20% 20% High End Imaging: CT/PET/MRI 10% 10% \$150 Tier 1; \$250 Tier 2 20% 20% Mental Health/Substance Abuse 10% \$55 \$70 \$60 \$70 Outpatient Rehab 10% \$15 \$0 20% 20% Lab Services, Outpatient 10% \$15 \$0 20% 20% Skilled Nursing Facility 10% 10% \$500 per impatient stay 20% 20% Outpatient Surger//Services 10% 10% \$515 Tier 1; 20% 20% Fier 1 \$5 \$5 \$15 \$15 \$15 \$15	Primary Care	10%	\$5	\$35	\$30	\$35
Urgent Care 10% \$15 \$75 \$100 \$75 ER Services 10% \$50 \$150 \$200 20% Inpatient Hospital 10% 10% \$500 per inpatient stay 20% 20% X-rays & other Diag. Imaging 10% 10% \$500 per inpatient stay 20% 20% High End Imaging: CT/PET/MRI 10% 10% \$150 Tier 1; \$250 Tier 2 20% 20% Tier 1; \$250 Tier 2 Mental Health/Substance Abuse - Office Visits 10% \$55 \$70 \$60 \$70 Speech/Occup/Phys Therapy, Outpatient Rehab 10% \$15 \$0 20% 20% Lab Services, Outpatient 10% 10% \$500 per inpatient stay 20% 20% Outpatient Surgery/Services 10% 10% \$500 per inpatient stay 20% 20% Pediatric Dental Coverage No No Yes Yes Yes Tier 1 \$55 \$55 \$15 \$15 \$15 \$15 Tier 2 \$15 \$20	Specialist Visit	10%	\$15	\$70	\$60	\$70
ER Services 10% \$50 \$150 \$200 20% Inpatient Hospital 10% 10% \$500 per inpatient stay 20% 20% X-rays & other Diag. Imaging 10% 10% \$50 20% 20% High End Imaging: CT/PET/MRI 10% 10% \$5150 Tier 1; \$250 Tier 2 20% 20% Mental Health/Substance Abuse - Office Visits 10% \$55 \$70 \$60 \$70 Outpatient Rehab 10% \$15 \$0 20% 20% Lab Services, Outpatient 10% \$15 \$0 20% 20% Skilled Nursing Facility 10% 10% \$500 per inpatient stay 20% 20% Outpatient Surgery/Services 10% 10% \$500 per inpatient stay 20% 20% Pediatric Dental Coverage No No Yes Yes Yes Tier 1 \$5 \$5 \$15 \$15 \$15 \$15 Tier 2 \$15 \$20 \$40 \$40 \$4	Preventative Care					
Inpatient Hospital 10% 10% \$500 per inpatient stay 20% 20% X-rays & other Diag. Imaging 10% 10% \$0 20% 20% High End Imaging: CT/PET/MRI 10% 10% \$150 Tier 1; \$250 Tier 2 20% 20% Mental Health/Substance Abuse - Office Visits 10% \$55 \$70 \$60 \$70 Speech/Occup/Phys Therapy, Outpatient Rehab 10% \$15 \$0 20% 20% Lab Services, Outpatient 10% 10% \$15 \$0 20% 20% Skilled Nursing Facility 10% 10% \$100 \$20% 20% 20% Outpatient Rehab 10% 10% \$0 20% 20% 20% Skilled Nursing Facility 10% 10% \$500 per inpatient stay 20% 20% 20% 20% Outpatient Surgery/Services 10% 10% \$150 Tier 1; \$250 Tier 2 20% \$20% Tier 2 Pediatric Dental Coverage No No Yes Yes Yes		\$0	\$0	\$0	\$0	\$0
Inpatient Hospital 10% 10% 10% inpatient stay 20% 20% X-rays & other Diag. Imaging 10% 10% \$0 20% 20% 20% High End Imaging: CT/PET/MRI 10% 10% \$150 Tier 1; \$250 Tier 2 20% \$20% Tier 1; \$250 Tier 2 Mental Health/Substance Abuse - Office Visits 10% \$5 \$70 \$60 \$70 Speech/Occup/Phys Therapy, Outpatient Rehab 10% \$15 \$0 20% 20% Lab Services, Outpatient 10% 10% \$50 20% 20% Skilled Nursing Facility 10% 10% \$50 per inpatient stay 20% 20% Outpatient Surgery/Services 10% 10% \$150 Tier 1; \$250 Tier 2 20% \$20% Tier 1; \$250 Tier 2 Pediatric Dental Coverage No No Yes Yes Yes Tier 1 \$5 \$5 \$15 \$15 \$15 Tier 2 \$15 \$20 \$40 \$40 Tier 3 \$30 \$30	Urgent Care					
High End Imaging: CT/PET/MRI 10% 10% \$150 Tier 1; \$250 Tier 2 20% 20% Tier 1; \$250 Tier 2 Mental Health/Substance Abuse 10% \$5 \$70 \$60 \$70 Speech/Occup/Phys Therapy, Outpatient Rehab 10% \$15 \$0 20% 20% Lab Services, Outpatient 10% 10% \$0 20% 20% Skilled Nursing Facility 10% 10% \$50 per inpatient stay 20% 20% Outpatient Surgery/Services 10% 10% \$150 Tier 1; \$250 Tier 2 20% 20% Pediatric Dental Coverage No No Yes Yes Yes Tier 1 \$5 \$5 \$15 \$15 \$15 Tier 2 \$15 \$20 \$40 \$40 \$40 Tier 3 \$30 \$30 \$70 \$70 \$70 Tier 4 \$50 \$50 \$100 \$100 \$100		10%	\$15	\$75	\$100	\$75
Inight End Intaging, Chrief 2 20% \$250 Tier 2 Mental Health/Substance Abuse 10% \$5 \$70 \$60 \$70 Speech/Occup/Phys Therapy, Outpatient Rehab 10% \$15 \$0 20% 20% Lab Services, Outpatient 10% 10% \$15 \$0 20% 20% Skilled Nursing Facility 10% 10% \$10% \$500 per inpatient stay 20% 20% Outpatient Surgery/Services 10% 10% \$500 per inpatient stay 20% 20% Pediatric Dental Coverage No No Yes Yes Yes Tier 1 \$5 \$5 \$15 \$15 \$15 Tier 2 \$15 \$20 \$40 \$40 Tier 3 \$30 \$30 \$70 \$70 Tier 4 \$50 \$50 \$100 \$100 \$100	ER Services	10%	\$15 \$50	\$75 \$150 \$500 per	\$100 \$200	\$75 20%
Office Visits 10% 55 \$70 500 \$70 Speech/Occup/Phys Therapy, Outpatient Rehab 10% \$15 \$0 20% 20% Lab Services, Outpatient 10% 10% \$0 20% 20% Skilled Nursing Facility 10% 10% \$500 per inpatient stay 20% 20% Outpatient Surgery/Services 10% 10% \$500 per inpatient stay 20% 20% Pediatric Dental Coverage No No Yes Yes Yes Tier 1 \$5 \$5 \$15 \$15 \$15 Tier 2 \$15 \$20 \$40 \$40 \$40 Tier 3 \$30 \$30 \$70 \$70 \$70 Tier 4 \$50 \$50 \$100 \$100 \$100 \$100	ER Services Inpatient Hospital	10% 10% 10%	\$15 \$50 10%	\$75 \$150 \$500 per inpatient stay	\$100 \$200 20%	\$75 20% 20%
Speech/Occup/Phys Therapy, Outpatient Rehab 10% \$15 \$0 20% 20% Lab Services, Outpatient 10% 10% \$0 20% 20% Skilled Nursing Facility 10% 10% \$500 per inpatient stay 20% 20% Outpatient Surgery/Services 10% 10% \$150 Tier 1; \$250 Tier 2 20% 20% Pediatric Dental Coverage No No Yes Yes Yes Tier 1 \$5 \$5 \$15 \$15 \$15 Tier 2 \$15 \$20 \$40 \$40 Tier 3 \$30 \$30 \$70 \$70 Tier 4 \$50 \$50 \$100 \$100 \$100	ER Services Inpatient Hospital X-rays & other Diag. Imaging	10% 10% 10% 10%	\$15 \$50 10% 10%	\$75 \$150 \$500 per inpatient stay \$0 \$150 Tier 1;	\$100 \$200 20% 20%	\$75 20% 20% 20% 20% 20% Tier 1;
Lab Services, Outpatient 10% 10% \$0 20% 20% Skilled Nursing Facility 10% 10% inpatient stay 20% 20% Outpatient Surgery/Services 10% 10% \$150 Tier 1; \$250 Tier 2 20% 20% Pediatric Dental Coverage No No Yes Yes Yes Tier 1 \$5 \$5 \$15 \$15 \$15 Tier 2 \$15 \$20 \$40 \$40 Tier 3 \$30 \$30 \$70 \$70 Tier 4 \$50 \$50 \$100 \$100 \$100	ER Services Inpatient Hospital X-rays & other Diag. Imaging High End Imaging: CT/PET/MRI Mental Health/Substance Abuse	10% 10% 10% 10% 10%	\$15 \$50 10% 10% 10%	\$75 \$150 \$500 per inpatient stay \$0 \$150 Tier 1; \$250 Tier 2	\$100 \$200 20% 20% 20%	\$75 20% 20% 20% 20% 20% Tier 1; \$250 Tier 2
Skilled Nutsing Facility 10% 10% 10% inpatient stay 20% 20% Outpatient Surgery/Services 10% 10% \$150 Tier 1; \$250 Tier 2 20% 20% 20% Pediatric Dental Coverage No No Yes Yes Yes Tier 1 \$55 \$55 \$15 \$15 \$15 Tier 2 \$15 \$20 \$40 \$40 \$40 Tier 3 \$30 \$30 \$70 \$70 \$70 Tier 4 \$50 \$50 \$100 \$100 \$100	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,	10% 10% 10% 10% 10%	\$15 \$50 10% 10% 10% \$5	\$75 \$150 \$500 per inpatient stay \$0 \$150 Tier 1; \$250 Tier 2 \$70	\$100 \$200 20% 20% 20% \$60	\$75 20% 20% 20% 20% 20% Tier 1; \$250 Tier 2 \$70
Outpatient Surgery/Services 10% 10% \$150 Tier 1; \$250 Tier 2 20% 20% Tier 1; \$250 Tier 2 Pediatric Dental Coverage No No Yes Yes Yes Tier 1 \$5 \$5 \$15 \$15 \$15 Tier 2 \$15 \$20 \$40 \$40 \$40 Tier 3 \$30 \$30 \$70 \$70 \$70 Tier 4 \$50 \$50 \$100 \$100 \$100	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	10% 10% 10% 10% 10% 10% 10%	\$15 \$50 10% 10% 10% \$5 \$15	\$75 \$150 \$500 per inpatient stay \$0 \$150 Tier 1; \$250 Tier 2 \$70 \$0 \$0	\$100 \$200 20% 20% 20% \$60 20%	\$75 20% 20% 20% 20% Tier 1; \$250 Tier 2 \$70 20%
Pediatric Dental Coverage No Yes Yes Yes Yes Tier 1 \$5 \$5 \$15 \$15 \$15 Tier 2 \$15 \$20 \$40 \$40 Tier 3 \$30 \$30 \$70 \$70 Tier 4 \$50 \$50 \$100 \$100	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	10% 10% 10% 10% 10% 10% 10%	\$15 \$50 10% 10% \$5 \$15 10%	\$75 \$150 \$500 per inpatient stay \$0 \$150 Tier 1; \$250 Tier 2 \$70 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$	\$100 \$200 20% 20% 20% \$60 20% 20%	\$75 20% 20% 20% 20% Tier 1; \$250 Tier 2 \$70 20% 20%
Tier 2 \$15 \$20 \$40 \$40 Tier 3 \$30 \$30 \$70 \$70 \$70 Tier 4 \$50 \$50 \$100 \$100 \$100	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	10% 10% 10% 10% 10% 10% 10% 10% 10% 10% 10%	\$15 \$50 10% 10% 10% \$5 \$15 10% 10%	\$75 \$150 \$500 per inpatient stay \$0 \$150 Tier 1; \$250 Tier 2 \$70 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$150 per inpatient stay \$150 Tier 1;	\$100 \$200 20% 20% 20% \$60 20% 20% 20% 20%	\$75 20% 20% 20% Tier 1; \$250 Tier 2 \$70 20% 20% 20% 20% 20% 20%
Tier 3 \$30 \$70 \$70 \$70 Tier 4 \$50 \$50 \$100 \$100	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	10% 10% 10% 10% 10% 10% 10% 10% 10% 10% 10% 10% 10% 10% 10% 10% 10% 10%	\$15 \$50 10% 10% \$5 \$15 10% 10% 10%	\$75 \$150 \$500 per inpatient stay \$0 \$150 Tier 1; \$250 Tier 2 \$70 \$0 \$0 \$0 \$0 \$500 per inpatient stay \$150 Tier 1; \$250 Tier 2	\$100 \$200 20% 20% 20% 20% 20% 20% 20% 20%	\$75 20% 20% 20% 20% Tier 1; \$250 Tier 2 \$70 20% 20% 20% 20% 20% 20%
Tier 4 \$50 \$100 \$100 \$100	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	10% 10% 10% 10% 10% 10% 10% 10% 10% 10%	\$15 \$50 10% 10% 10% \$5 \$15 10% 10% 10% No	\$75 \$150 \$500 per inpatient stay \$0 \$150 Tier 1; \$250 Tier 2 \$70 \$0 \$0 \$0 \$0 \$500 per inpatient stay \$150 Tier 1; \$250 Tier 2 Yes	\$100 \$200 20% 20% 20% 20% 20% 20% 20% 20% 20%	\$75 20% 20% 20% 20% Tier 1; \$250 Tier 2 \$70 20% 20% 20% 20% 20% 20% 20% 20%
	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	10% 10% 10% 10% 10% 10% 10% 10% 10% 10%	\$15 \$50 10% 10% \$5 \$15 10% 10% 10% 10% No \$5	\$75 \$150 \$500 per inpatient stay \$0 \$150 Tier 1; \$250 Tier 2 \$70 \$0 \$0 \$0 \$0 \$500 per inpatient stay \$150 Tier 1; \$250 Tier 2 Yes \$15	\$100 \$200 20% 20% 20% 20% 20% 20% 20% 20% 20%	\$75 20% 20% 20% 20% Tier 1; \$250 Tier 2 \$70 20% 20% 20% 20% 20% 20% 20% 20% 570 20% 20% 20% 20% 20% 20% 20% 20% 20% 20
Tier 5 N/A N/A N/A N/A N/A	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	10% 10% 10% 10% 10% 10% 10% 10% 10% 10%	\$15 \$50 10% 10% 10% \$5 \$15 10% 10% 10% 10% \$5 \$5 \$20	\$75 \$150 \$500 per inpatient stay \$0 \$150 Tier 1; \$250 Tier 2 \$70 \$0 \$0 \$0 \$0 \$500 per inpatient stay \$500 per inpatient stay \$250 Tier 2 \$250 Tier 2 \$250 Tier 2 \$150 Star 2 \$150 St	\$100 \$200 20% 20% 20% 20% 20% 20% 20% 20% 20%	\$75 20% 20% 20% 20% Tier 1; \$250 Tier 2 \$70 20% 20% 20% 20% 20% 20% 20% 5250 Tier 2 Yes \$15 \$40
	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	10% 10% 10% 10% 10% 10% 10% 10% 10% 10%	\$15 \$50 10% 10% 10% \$5 \$15 10% 10% 10% 10% \$5 \$20 \$30	\$75 \$150 \$500 per inpatient stay \$0 \$150 Tier 1; \$250 Tier 2 \$70 \$0 \$0 \$0 \$0 \$500 per inpatient stay \$150 Tier 1; \$250 Tier 2 Yes \$15 \$40 \$70	\$100 \$200 20% 20% 20% 20% 20% 20% 20% 20% 20%	\$75 20% 20% 20% 20% Tier 1; \$250 Tier 2 \$70 20% 20% 20% 20% 20% 20% 20% 570 20% 20% 50 Tier 1; \$250 Tier 2 \$75 \$40 \$70

BCBSRI: Blue Cross & Blue Shield of Rhode Island • NHPRI: Neighborhood Health Plan of Rhode Island • UHC: UnitedHealthcare