

2027

HealthSourceRI
FOR EMPLOYERS

Cost Sharing Reduction Plans

For Eligible Individuals and Families

Compare plans from the state's top insurence companies.

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 (94, 87, or 73), depending on your income and family size. The numbers refer to the percentage of expenses paid by your plan (Example: with a Silver 73 plan, on average, the plan covers 73% of expenses, and plan members will be responsible for the remaining 27% of expenses).

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):

CSR Level	Silver 94		Silver 87		Silver 73	
Range, as a percentage of the Federal Poverty Level (FPL)	Income between 100-150% FPL		Income between 150-200% FPL		Income between 200-250% FPL	
Family Size	You may qualify if your income is between:		You may qualify if your income is between:		You may qualify if your income is between:	
1	$15,960	$23,940	$23,940	$31,920	$31,920	$39,900
2	$21,640	$32,460	$32,460	$43,280	$43,280	$54,100
3	$27,320	$40,980	$40,980	$54,640	$54,640	$68,300
4	$33,000	$49,500	$49,500	$66,000	$66,000	$82,500
5	$38,680	$58,020	$58,020	$77,360	$77,360	$96,700
6	$44,360	$66,540	$66,540	$88,720	$88,720	$110,900

HealthSource RI Plan Comparison & Savings Tool

You can also use our **Plan Comparison & Savings Tool** at **HealthSourceRI.com/Calculator** to compare plan costs and estimate your savings. Just enter your age, family size and income and find the plan that best meets your needs and budget in less than 5 minutes.

When to Enroll or Renew

Open Enrollment runs November 1, 2026 through January 31, 2027. After Open Enrollment, you may enroll in coverage if you have a qualifying life event. Visit HealthSourceRI.com/SEP to learn more.

Important dates for picking 2027 health coverage:

November 1	Open Enrollment begins!
December 23	Pick a plan and pay to complete enrollment and make sure your ID cards arrive in time.
December 31	Very last day to pick and pay for coverage that begins January 2027. (ID cards will be delayed)
January 31	Open Enrollment ends — this is your last day to enroll for 2027 health coverage. Coverage purchased in January will be effective on February 1, 2027.

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.

How to Enroll or Renew

Visit HealthSourceRI.com to:

- Enroll or renew coverage
- Compare plans and costs through our **Plan Comparison & Savings Tool.** Most HealthSource RI customers receive financial help.

Call 1-855-840-4774

Call 211 to find Navigators in your area who can provide 1-on-1 enrollment support.

Health insurance is required in Rhode Island. Enroll today to avoid a tax penalty later.

All HSRI plans for Individuals and Families cover pediatric dental services. Preventive pediatric dental services are not subject to the deductible but other services may be: please check with your insurance company.

Rates as of November 1, 2026. 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.

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

BASIC PLAN INFORMATION

COST-SHARING REDUCTION (CSR) PLANS:
CSR plans are versions of Silver plans that have reduced deductibles, coinsurance, and copayments, with no difference in premium. You may qualify for a CSR plan based on your family size and how your income compares to the Federal Poverty Level. The number refers to the percentage of expenses paid by your plan. For example, with a Silver 73 plan, on average, the plan covers 73% of expenses, and the plan members will be responsible for the remaining 27% of expenses.

INDIVIDUAL PREMIUMS:
A premium is the amount you must pay each month for health insurance. Premiums vary by age and family size.

HEALTH SAVINGS ACCOUNTS (HSAs):
A Health Savings Account-qualified plan allows you to contribute to a separate tax-exempt account which can be used for healthcare expenses like deductibles and copayments.

HOW YOU GET YOUR CARE

Some insurers offer plans that include a smaller number of providers that the insurers have decided offer high-quality care at a lower cost. Plans have different monthly premiums and out-of-pocket costs for care, as well as different providers (like doctors and hospitals) 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.

When choosing a plan, you should consider the monthly premium, as well as any out-of-pocket costs, providers you prefer to visit, prescription drugs you take, and any other healthcare needs you have. All plans cover preventive healthcare services at no cost.

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 deductibles, copayments and coinsurance during the year.

DEDUCTIBLES

The **deductible** is the amount you must pay out-of-pocket for certain healthcare services before your insurance plan begins to pay. The deductible amount is separate from your monthly premium. Services subject to the deductible vary by plan and may include doctor visits and hospital stays, as well as prescription medications.

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.*

The **WHITE** area is not subject to the deductible. It is the dollar amount or percentage you pay per visit or healthcare 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 healthcare 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 healthcare providers that work together to coordinate your care. Visiting a PCMH provider may cost less in certain plans.

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 $36,450 for an individual or $75,000 for a family of four.

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.

INSURANCE COMPANY	BCBSRI	BCBSRI	NHPRI
PLAN NAME	VantageBlue Direct Plan (CSR94)	*BlueSolutions for HSA Direct (CSR94)	Neighborhood PRIMARY CSR94 0/0 (3)
METAL LEVEL	SILVER 94	SILVER 94	SILVER 94
PLAN INCOME RANGE % OF FEDERAL POVERTY LEVEL (FPL)	100-150% FPL	100-150% FPL	100-150% FPL
MONTHLY PREMIUM (21-YEAR OLD, BEFORE TAX CREDIT)	$665	$624	$492
MONTHLY PREMIUM (40-YEAR OLD, BEFORE TAX CREDIT)	$849	$798	$629
MONTHLY PREMIUM (60-YEAR OLD, BEFORE TAX CREDIT)	$1,804	$1,695	$1,335
HSA QUALIFIED	No	No	No
PLAN TYPE (SEE DEFINITIONS ON PAGE 2)	PPO	PPO	HMO
REFERRAL REQUIRED	No	No	No
NETWORK COVERAGE AREA	National	National	RI Only
RI PROVIDER INFORMATION (SUBJECT TO CHANGE)	1,578 PCPs 4,134 Specialists 436 Dentists 14 of 14 Hospitals	1,578 PCPs 4,134 Specialists 436 Dentists 14 of 14 Hospitals	1,336 PCPs 5,501 Specialists 503 Dentists 14 of 14 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
MAXIMUM OUT-OF-POCKET (MOOP) MEDICAL + DRUG	$1,900 Individual $3,800 Family	$1,900 Individual $3,800 Family	$2,600 Individual $5,200 Family
DEDUCTIBLE - MEDICAL	$0 Individual $0 Family	$0 Individual $0 Family	$0 Individual $0 Family
DEDUCTIBLE - DRUG	$0	$0	$0
IN-NETWORK COSTS:			
PRIMARY CARE	First sick visit free, all other visits: $20 Non-PCMH $10 PCMH	20%	First two sick visits free, all other visits: $5
SPECIALIST VISIT	$35	20%	$15
PREVENTATIVE CARE	$0	$0	$0
URGENT CARE	$75	20%	$15
EMERGENCY SERVICES	$300	20%	20%
INPATIENT HOSPITAL	20%	20%	20%
X-RAYS & OTHER DIAGNOSTIC IMAGING	20%	20%	20%
HIGH END IMAGING: CT / PET /MRI	20%	20%	20%
MENTAL HEALTH / SUBSTANCE ABUSE - OFFICE VISITS	$20	20%	First two visits free, all other visits: $5
SPEECH / OCCUPATIONAL / PHYSICAL THERAPY, OUTPATIENT REHAB	20%	20%	$15
LAB SERVICES, OUTPATIENT	20%	20%	20%
SKILLED NURSING FACILITY	20%	20%	20%
OUTPATIENT SURGERY / SERVICES	20%	20%	20%
ABORTION COVERAGE	Yes	Limited*	Yes[1]
Rx TIER 1	$10	$0	$1
Rx TIER 2	$35	$15	$5
Rx TIER 3	$60	$50	$20
Rx TIER 4	$80	$75	$40
Rx TIER 5	$150	$150	Tier 5/6: 50%, up to $150 copayment

*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 §156.280 (e)(3).
[1]A variation of this plan exists that excludes coverage for most abortions. An asterisk (*) at the beginning of the plan name indicates that it excludes most abortion coverage.

2027 Cost Sharing Reduction Plans for Eligible Individuals and Families

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

INSURANCE COMPANY	BCBSRI	BCBSRI	NHPRI	BCBSRI	BCBSRI
PLAN NAME	BlueCHiP Direct (CSR94)	BlueCHiP Direct Advance (CSR94)	Neighborhood PRIMARY CSR94 0/0 (1)	VantageBlue Direct Plan (CSR87)	*BlueSolutions for HSA Direct (CSR87)
METAL LEVEL	SILVER 94	SILVER 94	SILVER 94	SILVER 87	SILVER 87
PLAN INCOME RANGE % OF FEDERAL POVERTY LEVEL (FPL)	100-150% FPL	100-150% FPL	100-150% FPL	150-200% FPL	150-200% FPL
MONTHLY PREMIUM (21-YEAR OLD, BEFORE TAX CREDIT)	$617	$533	$459	$665	$624
MONTHLY PREMIUM (40-YEAR OLD, BEFORE TAX CREDIT)	$788	$681	$587	$849	$798
MONTHLY PREMIUM (60-YEAR OLD, BEFORE TAX CREDIT)	$1,674	$1,446	$1,247	$1,804	$1,695
HSA QUALIFIED	No	No	No	No	No
PLAN TYPE (SEE DEFINITIONS ON PAGE 2)	POS	POS	HMO	PPO	PPO
REFERRAL REQUIRED	Yes	Yes	No	No	No
NETWORK COVERAGE AREA	RI Only	RI Narrow	RI Only	National	National
RI PROVIDER INFORMATION (SUBJECT TO CHANGE)	1,578 PCPs 4,134 Specialists 436 Dentists 14 of 14 Hospitals	577 PCPs 1,565 Specialists 385 Dentists Brown University Health Hospitals: RI Hosp.; Hasbro; Miriam; Newport; Bradley	1,336 PCPs 5,501 Specialists 503 Dentists 14 of 14 Hospitals	1,578 PCPs 4,134 Specialists 436 Dentists 14 of 14 Hospitals	1,578 PCPs 4,134 Specialists 436 Dentists 14 of 14 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	$3,100 Individual $6,200 Family	$3,100 Individual $6,200 Family	$2,500 Individual $5,000 Family	$4,000 Individual $8,000 Family	$3,050 Individual $6,100 Family
DEDUCTIBLE - MEDICAL	$0 Individual $0 Family	$0 Individual $0 Family	$0 Individual $0 Family	$350 Individual $700 Family	$800 Individual $1,600 Family
DEDUCTIBLE - DRUG	$0	$0	$0	Tier 5 combined with medical	Combined with medical
IN-NETWORK COSTS:					
PRIMARY CARE	$15 Non-PCMH $5 PCMH	$15 Non-PCMH $5 PCMH	15%	First sick visit free, all other visits: $25 Non-PCMH $15 PCMH	20%
SPECIALIST VISIT	$20	$20	15%	$40	20%
PREVENTATIVE CARE	$0	$0	$0	$0	$0
URGENT CARE	$75	$75	15%	$75	20%
EMERGENCY SERVICES	10%	10%	15%	$300	20%
INPATIENT HOSPITAL	10%	10%	15%	20%	20%
X-RAYS & OTHER DIAGNOSTIC IMAGING	10%	10%	15%	20%	20%
HIGH END IMAGING: CT / PET /MRI	10%	10%	15%	20%	20%
MENTAL HEALTH / SUBSTANCE ABUSE - OFFICE VISITS	$15	$15	15%	$25	20%
SPEECH / OCCUPATIONAL / PHYSICAL THERAPY, OUTPATIENT REHAB	10%	10%	15%	20%	20%
LAB SERVICES, OUTPATIENT	10%	10%	15%	20%	20%
SKILLED NURSING FACILITY	10%	10%	15%	20%	20%
OUTPATIENT SURGERY / SERVICES	10%	10%	15%	20%	20%
ABORTION COVERAGE	Yes	Yes	Yes	Yes	Limited*
Rx TIER 1	$5	$5	$1	$10	$0
Rx TIER 2	$15	$15	$5	$40	$15
Rx TIER 3	$30	$30	$15	$80	$50
Rx TIER 4	$50	$50	$30	$100	$75
Rx TIER 5	$150	$150	Tier 5/6: 50%, up to $150 copayment	$150	$150

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[1]A variation of this plan exists that excludes coverage for most abortions. An asterisk (*) at the beginning of the plan name indicates that it excludes most abortion coverage.

2027 Cost Sharing Reduction Plans for Eligible Individuals and Families

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

INSURANCE COMPANY	BCBSRI	BCBSRI	NHPRI	NHPRI	BCBSRI
PLAN NAME	BlueCHiP Direct (CSR87)	BlueCHiP Direct Advance (CSR87)	Neighborhood PRIMARY CSR87 1400/2800	Neighborhood PRIMARY CSR87 900/1800	VantageBlue Direct Plan (CSR73)
METAL LEVEL	SILVER 87	SILVER 87	SILVER 87	SILVER 87	SILVER 73
PLAN INCOME RANGE % OF FEDERAL POVERTY LEVEL (FPL)	150-200% FPL	150-200% FPL	150-200% FPL	150-200% FPL	200-250% FPL
MONTHLY PREMIUM (21-YEAR OLD, BEFORE TAX CREDIT)	$617	$533	$492	$459	$665
MONTHLY PREMIUM (40-YEAR OLD, BEFORE TAX CREDIT)	$788	$681	$629	$587	$849
MONTHLY PREMIUM (60-YEAR OLD, BEFORE TAX CREDIT)	$1,674	$1,446	$1,335	$1,247	$1,804
HSA QUALIFIED	No	No	No	No	No
PLAN TYPE (SEE DEFINITIONS ON PAGE 2)	POS	POS	HMO	HMO	PPO
REFERRAL REQUIRED	Yes	Yes	No	No	No
NETWORK COVERAGE AREA	RI Only	RI Narrow	RI Only	RI Only	National
RI PROVIDER INFORMATION (SUBJECT TO CHANGE)	1,578 PCPs 4,134 Specialists 436 Dentists 14 of 14 Hospitals	577 PCPs 1,565 Specialists 385 Dentists Brown University Health Hospitals: RI Hosp.; Hasbro; Miriam; Newport; Bradley	1,336 PCPs 5,501 Specialists 503 Dentists 14 of 14 Hospitals	1,336 PCPs 5,501 Specialists 503 Dentists 14 of 14 Hospitals	1,578 PCPs 4,134 Specialists 436 Dentists 14 of 14 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	$3,500 Individual $7,000 Family	$3,500 Individual $7,000 Family	$3,250 Individual $6,500 Family	$3,250 Individual $6,500 Family	$9,400 Individual $18,800 Family
DEDUCTIBLE - MEDICAL	$950 Individual $1,900 Family	$950 Individual $1,900 Family	$1,400 Individual $2,800 Family	$900 Individual $1,800 Family	$5,600 Individual $11,200 Family
DEDUCTIBLE - DRUG	Tiers 3, 4, and 5 combined with medical	Tiers 3, 4, and 5 combined with medical	Tiers 4, 5, and 6 combined with medical	Tiers 2, 3, 4, 5, and 6 combined with medical	Tier 5 combined with medical
IN-NETWORK COSTS:					
PRIMARY CARE	$20 Non-PCMH $10 PCMH	$20 Non-PCMH $10 PCMH	First two sick visits free, all other visits: $5	15%	First sick visit free, all other visits: $60 Non-PCMH $40 PCMH
SPECIALIST VISIT	$25	$25	$15	15%	$65
PREVENTATIVE CARE	$0	$0	$0	$0	$0
URGENT CARE	$75	$75	$15	15%	$75
EMERGENCIES SERVICES	10%	10%	20%	15%	$475
INPATIENT HOSPITAL	10%	10%	20%	15%	30%
X-RAYS & OTHER DIAGNOSTIC IMAGING	10%	10%	20%	15%	30%
HIGH END IMAGING: CT / PET / MRI	10%	10%	20%	15%	30%
MENTAL HEALTH / SUBSTANCE ABUSE - OFFICE VISITS	$20	$20	First two visits free, all other visits: $5	15%	$60
SPEECH / OCCUPATIONAL /PHYSICAL THERAPY, OUTPATIENT REHAB	10%	10%	$15	15%	30%
LAB SERVICES, OUTPATIENT	10%	10%	20%	15%	30%
SKILLED NURSING FACILITY	10%	10%	20%	15%	30%
OUTPATIENT SURGERY / SERVICES	10%	10%	20%	15%	30%
ABORTION COVERAGE	Yes	Yes	Yes[1]	Yes	Yes
Rx TIER 1	$7	$7	$5	$3	$10
Rx TIER 2	$25	$25	$10	$10	$45
Rx TIER 3	$50	$50	$45	$35	$90
Rx TIER 4	$75	$75	$65	$50	$125
Rx TIER 5	$150	$150	Tier 5/6: 50%, up to $150 copayment	Tier 5/6: 50%, up to $150 copayment	$150

*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 §156.280 (e)(3).
[1]A variation of this plan exists that excludes coverage for most abortions. An asterisk (*) at the beginning of the plan name indicates that it excludes most abortion coverage.

2027 Cost Sharing Reduction Plans for Eligible Individuals and Families

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

INSURANCE COMPANY	BCBSRI	BCBSRI	BCBSRI	NHPRI	NHPRI
PLAN NAME	*BlueSolutions for HSA Direct (CSR73)	BlueCHiP Direct (CSR73)	BlueCHiP Direct Advance (CSR73)	Neighborhood PRIMARY CSR73 4950/9900	Neighborhood PRIMARY CSR73 3675/7350
METAL LEVEL	SILVER 73	SILVER 73	SILVER 73	SILVER 73	SILVER 73
PLAN INCOME RANGE % OF FEDERAL POVERTY LEVEL (FPL)	200-250% FPL	200-250% FPL	200-250% FPL	200-250% FPL	200-250% FPL
MONTHLY PREMIUM (21-YEAR OLD, BEFORE TAX CREDIT)	$624	$617	$533	$492	$459
MONTHLY PREMIUM (40-YEAR OLD, BEFORE TAX CREDIT)	$798	$788	$681	$629	$587
MONTHLY PREMIUM (60-YEAR OLD, BEFORE TAX CREDIT)	$1,695	$1,674	$1,446	$1,335	$1,247
HSA QUALIFIED	Yes	No	No	No	No
PLAN TYPE (SEE DEFINITIONS ON PAGE 2)	PPO	POS	POS	HMO	HMO
REFERRAL REQUIRED	No	Yes	Yes	No	No
NETWORK COVERAGE AREA	National	RI Only	RI Narrow	RI Only	RI Only
RI PROVIDER INFORMATION (SUBJECT TO CHANGE)	1,578 PCPs 4,134 Specialists 436 Dentists 14 of 14 Hospitals	1,578 PCPs 4,134 Specialists 436 Dentists 14 of 14 Hospitals	577 PCPs 1,565 Specialists 385 Dentists Brown University Health Hospitals: RI Hosp.; Hasbro; Miriam; Newport; Bradley	1,336 PCPs 5,501 Specialists 503 Dentists 14 of 14 Hospitals	1,336 PCPs 5,501 Specialists 503 Dentists 14 of 14 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	$7,500 Individual $15,000 Family	$8,700 Individual $17,400 Family	$8,700 Individual $17,400 Family	$8,430 Individual $16,860 Family	$7,500 Individual $15,000 Family
DEDUCTIBLE - MEDICAL	$3,200 Individual $6,400 Family	$4,200 Individual $8,400 Family	$4,150 Individual $8,300 Family	$4,950 Individual $9,900 Family	$3,675 Individual $7,350 Family
DEDUCTIBLE - DRUG	Combined with medical	Tiers 3, 4, and 5 combined with medical	Tiers 3, 4, and 5 combined with medical	Tiers 4, 5, and 6 combined with medical	Tiers 2, 3, 4, 5, and 6 combined with medical
IN-NETWORK COSTS:					
PRIMARY CARE	20%	$30 Non-PCMH $20 PCMH	$40 Non-PCMH $20 PCMH	First two sick visits free, all other visits: $25	15%
SPECIALIST VISIT	20%	$60	$60	$75	15%
PREVENTATIVE CARE	$0	$0	$0	$0	$0
URGENT CARE	20%	$75	$75	$75	15%
EMERGENCY SERVICES	20%	10%	10%	50%	15%
INPATIENT HOSPITAL	20%	10%	10%	50%	15%
X-RAYS & OTHER DIAGNOSTIC IMAGING	20%	10%	10%	50%	15%
HIGH END IMAGING: CT / PET / MRI	20%	10%	10%	50%	15%
MENTAL HEALTH / SUBSTANCE ABUSE - OFFICE VISITS	20%	$30	$40	First two visits free, all other visits: $25	15%
SPEECH / OCCUP / PHYS THERAPY, OUTPATIENT REHAB	20%	10%	10%	$75	15%
LAB SERVICES, OUTPATIENT	20%	10%	10%	50%	15%
SKILLED NURSING FACILITY	20%	10%	10%	50%	15%
OUTPATIENT SURGERY / SERVICES	20%	10%	10%	50%	15%
ABORTION COVERAGE	Limited*	Yes	Yes	Yes[1]	Yes
Rx TIER 1	$0	$7	$7	$5	$5
Rx TIER 2	$15	$35	$35	$15	$10
Rx TIER 3	$50	$50	$50	$50	$40
Rx TIER 4	$75	$75	$75	$75	$65
Rx TIER 5	$150	$150	$150	Tier 5/6: 50%, up to $150 copayment	Tier 5/6: 50%, up to $150 copayment

*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 §156.280 (e)(3).
[1]A variation of this plan exists that excludes coverage for most abortions. An asterisk (*) at the beginning of the plan name indicates that it excludes most abortion coverage.