



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan document at www.employeebenefits.ri.gov or by calling UnitedHealthcare at 1-866-202-0434.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$250 individual \$500 Family	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For in-network providers there is an out-of-pocket limit of \$250 individual and \$500 family. For out-of-network providers \$3,000 person / \$9,000 family.	For in-network and out-of-network providers the out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Premiums, balance-billed charges, health care this plan doesn't cover, and co-payments for prescription drug services.	Even though you pay these expenses, they don't count toward the medical out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes. See www.myuhc.com or call 1-866-202-0434 for a list of participating providers	If you use an in-network provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network provider may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your plan document for additional information about excluded services .

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- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 co-pay/visit	20% co-insurance	----- none -----
	Specialist visit	\$25 co-pay/visit	20% co-insurance	----- none -----
	Other practitioner office visit	\$25 co-pay/visit for chiropractor \$25 co-pay/visit for podiatrist	20% co-insurance for chiropractor 20% co-insurance for podiatrist	Chiropractor coverage limited to 12 visits per year. Routine foot care only covered for severe systemic disease or preventive treatments for diabetes. Mental health service providers must meet certain criteria; pre-authorization recommended. Cardiac rehabilitation limited to 3 visits per week for up to 12 weeks; must meet certain criteria; pre-authorization recommended. Respiratory therapy must occur up to 14 days prior to hospital admission or up to 6 weeks after hospital discharge.
		\$15 co-pay/visit for mental health services	20% co-insurance for mental health services	
	Preventive care/screening/immunization	No charge	20% co-insurance	----- none -----

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RI State Employee Health Plan: Individual & Family Plans

Coverage Period: 01/01/2015 – 12/31/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individuals & Families | Plan Type: Choice Plus

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% co-insurance	----- none -----
	Imaging (CT/PET scans, MRIs)	No charge if deductible has been met	20% co-insurance	----- none -----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Tier 1 (most generic drugs)	\$7 co-pay/prescription (retail) \$14 co-pay/prescription (mail order)	\$7 co-pay/prescription (retail) plus balance billing	Covers up to a 31-day supply (retail prescription); 90-day supply (mail order prescription).
	Tier 2 (preferred brand name drugs)	\$25 co-pay/prescription (retail) \$50 co-pay/prescription (mail order)	\$25 co-pay/prescription (retail) plus balance billing	Covers up to a 31-day supply (retail prescription); 90-day supply (mail order prescription).
	Tier 3 (non-preferred brand name drugs)	\$45 co-pay/prescription (retail) \$90 co-pay/prescription (mail order)	\$45 co-pay/prescription (retail) plus balance billing	Covers up to a 31-day supply (retail prescription); 90-day supply (mail order prescription).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge if deductible has been met	20% co-insurance	----- none -----
	Physician/surgeon fees	No charge if deductible has been met	20% co-insurance	----- none -----
If you need immediate medical attention	Emergency room services	\$125 co-pay/visit; waived if admitted to hospital within 24 hours	\$125 co-pay/visit; waived if admitted to hospital within 24 hours	First visit to emergency room must be within 24 hours of accident or onset of symptoms; no emergency room coverage for non-emergency conditions.
	Emergency medical transportation	No charge	No charge	For air and water transportation, no charge up to a \$3,000 maximum benefit per occurrence.
	Urgent care	\$50 co-pay/visit	20% co-insurance	----- none -----

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge if deductible has been met	20% co-insurance	For out-of-network providers, failure to obtain pre-authorization may result in denial of benefit.
	Physician/surgeon fee	No charge if deductible has been met	20% co-insurance	----- none -----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15 co-pay/visit	20% co-insurance	For out-of-network providers, failure to obtain pre-authorization may result in denial of benefits for some services.
	Mental/Behavioral health inpatient services	No charge if deductible has been met	20% co-insurance	For out-of-network providers, failure to obtain pre-authorization may result in denial of benefits.
	Substance use disorder outpatient services	\$15 co-pay/visit	20% co-insurance	For out-of-network providers, failure to obtain pre-authorization may result in denial of benefits for some services.
	Substance use disorder inpatient services	No charge if deductible has been met	20% co-insurance	For out-of-network providers, failure to obtain pre-authorization may result in denial of benefits.
If you are pregnant	Prenatal and postnatal care	\$25 co-pay for first prenatal care office visit, then no charges for further prenatal care office visits	20% co-insurance	Postnatal care for newborns covered for the first 31 days, excluding newborns of dependent children.
	Delivery and all inpatient services	No charge if deductible has been met	20% co-insurance	----- none -----
If you need help recovering or have other special health needs	Home health care	No charge	20% co-insurance	20% co-insurance when care is not part of a coordinated home care program. For out-of-network providers, failure to obtain pre-authorization may result in denial of benefits.
	Rehabilitation services	20% co-insurance	20% co-insurance	No charge for services performed within 30 days of hospital stay, home care program or ambulatory surgery.

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Coverage Period: 01/01/2015 – 12/31/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you need help recovering or have other special health needs	Habilitation services	No charge	No charge	For more information, see “Early Intervention Services” at pages 23-24 of Summary Plan Description.
	Skilled nursing care	No charge if deductible has been met	20% co-insurance	For out-of-network providers, failure to obtain pre-authorization may result in denial of benefit.
	Durable medical equipment	No charge if deductible has been met	20% co-insurance	Rented or purchased equipment must be pre-authorized; batteries necessary for equipment use are not covered.
	Hospice service	No charge if deductible has been met	20% co-insurance	For out-of-network providers, failure to obtain pre-authorization may result in denial of benefit.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	----- none -----
	Glasses	Not covered	Not covered	----- none -----
	Dental check-up	Not covered	Not covered	----- none -----

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan document for other excluded services .)		
<ul style="list-style-type: none"> Acupuncture Bariatric surgery, unless deemed medically necessary by a physician Cosmetic surgery 	<ul style="list-style-type: none"> Dental care (Adult and Child), unless necessary due to accidental damage Long-term care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Private-duty nursing Routine eye care (Adult and Child) Routine foot care Weight loss programs

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Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids
- Infertility treatment

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-401-222-3160**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at **1-877-267-2323 x51565** or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- **UnitedHealthcare** at **1-866-202-0434** or www.myuhc.com
- **CVS Caremark** at **1-800-307-5432** or www.caremark.com
- **State of Rhode Island Office of Employee Benefits** at **1-401-222-3160** or www.employeebenefits.ri.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the “minimum value standard.” **This health coverage does meet the minimum value standard for the benefits it provides.**

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays \$7,290**
- **Patient pays \$250**

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$250
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$0
Total	\$250

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan pays \$4,750**
- **Patient pays \$650**

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$250
Prescription Co-pays	\$320
Medical Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$650

Note: These numbers assume the patient is participating in our Diabetes Management Program. If you have diabetes and do not participate in the program, your costs may be higher. For more information about the Diabetes Management Program, please contact UnitedHealthcare at 1-866-202-0434.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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