



Brown University : Brown Premier Medical Plan



This Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-855-704-5366. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or www.cciio.cms.gov or call 1-855-704-5366 to request a copy.

| Important Questions | Answers | Why this Matters: |
|--|--|---|
| What is the overall deductible? | In-Network \$250 person/ \$500 family. Out-of-Network \$500 person/ \$1,000 family. | Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your deductible? | Yes. In-Network <u>preventive care</u> services are covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the out-of-pocket limit for this plan? | In-Network \$3,500 person/ \$7,000 family. Out-of-Network \$3,500 person/ \$7,000 family. | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the out-of-pocket limit? | <u>Premiums</u> , <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a network provider? | Yes. See MyHealthToolkitRI.com or call 1-800-810-BLUE (2583) for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |



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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$20 <u>Copay</u> / visit; <u>deductible</u> does not apply | 20% <u>Coinsurance</u> | Teladoc visits are covered at No Charge. |
| | <u>Specialist</u> visit | \$30 <u>Copay</u> / visit; <u>deductible</u> does not apply | 20% <u>Coinsurance</u> | Teladoc dermatology visits are covered at No Charge. |
| | <u>Preventive care/screening/immunization</u> | No Charge | 20% <u>Coinsurance</u> | See www.healthcare.gov for <u>preventive care</u> guidelines. There may be additional benefits available. See your Employer for details. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 0% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | None |
| | Imaging (CT/PET scans, MRIs) | 0% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | None |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at MyHealthToolkitRI.com | Generic drugs (Retail) | \$10 copay, deductible does not apply | 20% coinsurance with a \$45 copay, deductible does not apply | See your Employer for benefit details. |
| | Generic drugs (Mail Order) | \$20 copay, deductible does not apply | Not Covered | See your Employer for benefit details. |
| | Preferred brand drugs (Retail) | \$30 copay, deductible does not apply | 20% coinsurance with a \$45 copay, deductible does not apply | See your Employer for benefit details. |
| | Preferred brand drugs (Mail Order) | \$60 copay, deductible does not apply | Not Covered | See your Employer for benefit details. |
| | Non-preferred brand drugs (Retail) | \$50 copay, deductible does not apply | 20% coinsurance with a \$45 copay, deductible does not apply | See your Employer for benefit details. |
| | Non-preferred brand drugs (Mail Order) | \$100 copay, deductible does not apply | Not Covered | See your Employer for benefit details. |
| | <u>Specialty drugs</u> | N/A | N/A | See your Employer for benefit details. |

| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 0% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | None |
|--|--|--|--|--|
| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
| | | <u>In-Network Provider</u> (You will pay the least) | <u>Out-of-Network Provider</u> (You will pay the most) | |
| | Physician/surgeon fees | 0% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> | \$150 <u>Copay</u> / visit; <u>deductible</u> does not apply | \$150 <u>Copay</u> / visit; <u>deductible</u> does not apply | <u>Copayment</u> will be waived if admitted. |
| | <u>Emergency medical transportation</u> | \$50 <u>Copay</u> ; <u>deductible</u> does not apply | \$50 <u>Copay</u> ; <u>deductible</u> does not apply | None |
| | <u>Urgent care</u> | \$30 <u>Copay</u> / visit; <u>deductible</u> does not apply | 20% <u>Coinsurance</u> | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 0% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | <u>Pre-authorization</u> is required. |
| | Physician/surgeon fees | 0% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Mental/behavioral health outpatient services | 0% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | Teladoc behavioral health visits are covered with at No Charge. In-Network office visits are covered with a \$20 <u>Copay</u> . |
| | Substance use disorder outpatient services | 0% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | |
| | Mental/behavioral health inpatient services | 0% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | <u>Pre-authorization</u> is required. |
| | Substance use disorder inpatient services | 0% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | |
| If you are pregnant | Office visits | \$20 <u>Copay</u> / visit; <u>deductible</u> does not apply | 20% <u>Coinsurance</u> | <u>Pre-authorization</u> for facility services is required. <u>Copay</u> applies to the initial visit only. Subsequent visits are covered at No Charge. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. |

| | | | | |
|--|---|-----------------------|------------------------|--|
| | Childbirth/delivery professional services | 0% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery facility services | 0% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|----------------------------------|---|---|---|
| | | <u>In-Network Provider</u> (You will pay the least) | <u>Out-of-Network Provider</u> (You will pay the most) | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 0% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | None |
| | <u>Rehabilitation services</u> | 0% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | 30 visits/benefit year for Pulmonary Rehabilitation therapy. 36 visits/benefit year for Cardiac Rehabilitation Therapy. |
| | <u>Habilitation services</u> | 0% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | 30 visits/benefit year for Pulmonary Rehabilitation therapy. 36 visits/benefit year for Cardiac Rehabilitation Therapy. |
| | <u>Skilled nursing care</u> | 0% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | 100 days/benefit year. <u>Pre-authorization</u> is required. |
| | <u>Durable medical equipment</u> | 0% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | Wigs are limited to 1 unit/benefit year. Hearing aids are limited to 1 aid/ear, every 2 years. |
| | <u>Hospice services</u> | 0% <u>Coinsurance</u> | 20% <u>Coinsurance</u> | None |
| If your child needs dental or eye care | Children's eye exam | \$30 <u>Copay</u> / visit; <u>deductible</u> does not apply | 20% <u>Coinsurance</u> | Limited to 1 exam/benefit year. |
| | Children's glasses | Not Covered | Not Covered | See your Employer for benefit details. |
| | Children's dental check-up | Not Covered | Not Covered | See your Employer for benefit details. |

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|-----------------------|-----------------------|------------------------|
| • Cosmetic Surgery | • Dental Care (Child) | • Routine Foot Care |
| • Dental Care (Adult) | • Long-Term Care | • Weight Loss Programs |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|---|--|---|
| • Acupuncture, 12 visits/benefit year | • Hearing Aids | • Private-Duty Nursing, if part of pre-authorized <u>home health care</u> |
| • Bariatric Surgery, 1 Surgery/lifetime | • Infertility Treatment | • Routine Eye Care (Adult) |
| • Chiropractic Care, 12 visits/benefit year | • Non-emergency care when traveling outside the U.S. | • Routine Eye Care (Child) |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-855-704-5366 or visit us at MyHealthToolkitRI.com, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish: Para obtener asistencia en español, llame al número de atención al cliente que aparece en la primera página de esta notificación.

Tagalog: Upang makakuha ng tulong sa Tagalog, tawagan ang numero ng *customer service* na makikita sa unang pahina ng paunawang ito.

Chinese: 如需中文服务，请致电列于本通知首页的客户服务号码。

Navajo: T'áá Dinéji shíł hane'go shiká i'doolwoł nínizingo éi Nidaalnishigíí Áká Anídaalwo'ígíí, customer service, bich'í' hodiilnih. Bik'ehgo bich'í' hane'ígíí éi díi naaltsoos neiyi'nilígíí akáa'gí síłtsoozígíí bikáá' íishjááh.

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:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

| Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery) | Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | Mia's Simple Fracture (in-network emergency room visit and follow up care) |
|---|---|---|
| <ul style="list-style-type: none"> - The <u>plan's</u> overall <u>deductible</u> \$250 - <u>Specialist Copayment</u> \$30 - <u>Hospital (facility) Coinsurance</u> 0% - <u>Other Coinsurance</u> 0% | <ul style="list-style-type: none"> - The <u>plan's</u> overall <u>deductible</u> \$250 - <u>Specialist Copayment</u> \$30 - <u>Hospital (facility) Coinsurance</u> 0% - <u>Other Coinsurance</u> 0% | <ul style="list-style-type: none"> - The <u>plan's</u> overall <u>deductible</u> \$250 - <u>Specialist Copayment</u> \$30 - <u>Hospital (facility) Coinsurance</u> 0% - <u>Other Coinsurance</u> 0% |
| <p>This EXAMPLE event includes services like: <u>Specialist</u> office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (ultrasounds and blood work) <u>Specialist</u> visit (anesthesia)</p> | <p>This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (including disease education) <u>Diagnostic tests</u> (blood work) Prescription drugs <u>Durable medical equipment</u> (glucose meter)</p> | <p>This EXAMPLE event includes services like: <u>Emergency room care</u> (including medical supplies) <u>Diagnostic test</u> (x-ray) <u>Durable medical equipment</u> (crutches) <u>Rehabilitation services</u> (physical therapy)</p> |
| Total Example Cost | Total Example Cost | Total Example Cost |
| \$12,700 | \$5,600 | \$2,800 |
| In this example, Peg would pay: | In this example, Joe would pay: | In this example, Mia would pay: |
| <i>Cost Sharing</i> | <i>Cost Sharing</i> | <i>Cost Sharing</i> |
| <u>Deductibles</u> | <u>Deductibles</u> | <u>Deductibles</u> |
| \$250 | \$140 | \$250 |
| <u>Copayments</u> | <u>Copayments</u> | <u>Copayments</u> |
| \$0 | \$2,030 | \$300 |
| <u>Coinsurance</u> | <u>Coinsurance</u> | <u>Coinsurance</u> |
| \$0 | \$0 | \$0 |
| <i>What isn't covered</i> | <i>What isn't covered</i> | <i>What isn't covered</i> |
| Limits or exclusions | Limits or exclusions | Limits or exclusions |
| \$70 | \$80 | \$100 |
| The total Peg would pay is | The total Joe would pay is | The total Mia would pay is |
| \$320 | \$2,250 | \$560 |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: **1-855-704-5366**.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره ی این برنامه ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nilwo'ígíí díí Béeso Ách'ááh naa'níligi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíí bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'í' ha desdzih nínízingo, kojí' béesh bee hólne' 1-844-516-6328. (Navajo)
