Conduent Human Resource Services

CONDUENT

The Town of Smithfield

Actuarial Valuation Report for

Fiscal Year July 1, 2016 – June 30, 2017

Information Required Under Governmental Accounting Standards Board Statement No. 74/75

October 2017

CONDUENT

Brian J. Hlava, ASA, MAAA, FCA
Director, Consulting Actuary

Conduent HR Services, LLC
500 Plaza Drive
Secaucus, NJ 07096

brian.hlava@conduent.com
Tel 201.902.2962
Fax 201.902.2883

November 15, 2017

Mr. Randy Rossi
Town Manager
Town of Smithfield
64 Farnum Pike, Smithfield, RI 02917

Dear Randy,

Conduent was retained to complete this actuarial valuation report which provides information for the Town of Smithfield ("Smithfield") Postretirement Benefits Plan ("Plan") for the fiscal year ending June 30, 2017. The purposes of the valuation are to measure the fiduciary net position of the Plan and to provide reporting and disclosure information for financial statements of the Plan and of Smithfield, as well as for governmental agencies and other interested parties. This valuation report contains information that is required for compliance with the Governmental Accounting Standards Board's Statement 74 (i.e., Financial Reporting for Postemployment Benefit Plans Other than Pension Plans) and 75 (i.e., Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions)("GASB 74 and 75").

Purpose of This Report

GASB 74 and 75, replace Statements No. 43 and 45, respectively. GASB 74 is effective for fiscal years beginning after June 15, 2016. Since the fiscal year measured in this report began after this date, GASB 74 must be reflected. GASB 75 is effective for fiscal years beginning after June 15, 2017. For simplicity, Smithfield has elected to adopt GASB 75 for Fiscal Year 2017. Early adoption is encouraged under GASB 75 standards.

Smithfield may use this report as a source of information for its financial statements. Use of this report for any other purpose may not be appropriate and may result in mistaken conclusions due to failure to understand applicable assumptions, methodologies, or inapplicability of the report for that purpose. This report should not be provided except in its entirety.

Because of the risk of misinterpretation of actuarial results, you should ask Conduent to review any statement you wish to make on the results contained in this report. Conduent will accept no liability for any such statements made without prior review by Conduent.

Future actuarial measurements may differ significantly from current measurements due to such factors as the following: retiree group benefits program experience differing from that anticipated by the assumptions, changes in assumptions, changes expected as part of the natural operation of the methodology used for these measurements (such as the end of an amortization period), and changes in plan provisions, applicable law or regulations. Retiree group benefit models necessarily rely on the use of approximations and estimates and are sensitive to changes in these approximations and estimates. Small variations in these approximations and estimates may lead to significant changes in actuarial measurements. An analysis of the potential range of such future differences other than the required disclosures related to the sensitivity to discount rate and healthcare cost trend rate assumptions is beyond the scope of this report.

Data, Assumptions, Methods and Plan Provisions

This valuation was performed using employee census data, claims and enrollment data, asset information, and plan provisions provided by Smithfield personnel. Although we did not audit the data, we reviewed the data for reasonableness and consistency with the prior year's information. A detailed review of the data and its sources beyond that necessary to develop the analysis was not performed and is beyond the scope of the analysis. The results of the valuation are dependent on the accuracy of the data.

The entry age normal liabilities presented herein were determined as of July 1, 2016 using data as of that date provided by Smithfield. The total OPEB liability as of June 30, 2017 was determined based on a no gain/loss roll-forward of the July 1, 2016 valuation.

The assumptions, methods, and plan provisions used were the same as those in the Smithfield Retiree Medical Actuarial Valuation under GASB 45 for FYE June 30, 2016 report, except for the following:

- The per capita costs based on current plan premiums increased the liability 3.3%.
- The age-related morbidity factors were updated based on "Health Care Costs—From Birth to Death" sponsored by the Society of Actuaries and prepared by Dale H. Yamamoto (May 2013). This increased the liability 13.0%.
- The actuarial cost method used was revised to the Entry Age Normal level percent of pay method, consistent with the requirements of GASB 74 and 75. The cost method decreased the liability 7.2%.
- The health care cost trend schedule was updated to 8.5% for FY 2017 grading down to 4.5% in FY 2025. This increased the liability 6.0%.
- The mortality improvement scale was changed to MP-2016. This decreased the liability 0.3%.
- The withdrawal and retirement decrement assumptions were updated based on the experience study titled "Employees' Retirement System Of Rhode Island Actuarial Experience Investigation For The Six–Year Period Ending June 30, 2013" performed by Gabriel Roeder Smith & Company on June 18, 2014 as described in more detail in Appendix A. This increased the liability 6.8%.
- The discount rate was updated in accordance with GASB 74 and 75 to be 2.71% for the beginning of year liability and 3.14% for the end of year liability. These compare to the 5.40% discount rate as of July 1, 2016 that was used in the previous valuation. The decrease from 5.40% to 2.71% caused a 29.6% increase in the liability.
- The Net OPEB Obligation and the Annual Required Contribution as defined in GASB 45 are no longer determined, since they are no longer required to be disclosed on the Annual Financial Statement. The net OPEB liability will be reported on the balance sheet instead of the Net OPEB Obligation and the annual OPEB expense recognized on the statement of activities (income statement) is based on the net OPEB liability change between reporting dates. Some changes will be recognized immediately, others amortized over several years.

Actuarial Certification

The assumptions used for financial accounting purposes were selected by the plan sponsor with our advice. In our opinion, the actuarial assumptions used are appropriate for purposes of the valuation and are reasonably related to the experience of the Plan and to reasonable long-term expectations. The cost results and actuarial exhibits presented in this report were determined on a consistent and objective basis in accordance with applicable Actuarial Standards of Practice and generally accepted actuarial procedures. To the best of our knowledge, the information fairly presents the actuarial position of the Smithfield Postretirement Benefits Plan in accordance with the requirements of GASB Statement No. 74 and 75 as of June 30, 2017.

It is important to note that the measurement of postretirement medical obligations is extremely sensitive to the assumptions chosen. The results presented above and in more detail in the next sections are based upon one set of reasonable assumptions. Other sets of equally reasonable assumptions can yield materially lesser or greater obligations.

This report represents a statement of actuarial opinion by the undersigned actuary. Brian Hlava is an Associate of the Society of Actuaries, and a Member of the American Academy of Actuaries. He has met the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. This report has been prepared in accordance with all applicable Actuarial Standards of Practice and he is available to answer questions about it.

Respectfully submitted,

Brian Hlava
Signing Actuary, ASA, FCA, MAAA
Director, Health & Productivity
Conduent HR Services, LLC

Enc

Doc: Smithfield 2017 Expense GASB 74 And 75.Docx

Contents

GASB 74 Information

Summary of Significant Accounting Policies

Method used to value investments: Investments are reported at fair value.

Plan Description

Plan administration: Smithfield administers the Smithfield Postretirement Benefits Plan ("Plan"), a single-employer defined benefit Postretirement Benefits Plan. The Plan covers eligible retirees and disabled employees of Smithfield, as well as their spouses and survivors. Smithfield established the Retiree Benefits Trust to fund the future payments required to provide post-employment benefits other than pension ("OPEB").

Plan membership:

Membership Status as of July 1, 2016	Count
Inactive plan members or beneficiaries currently receiving benefits	75
Inactive plan members entitled to but not yet receiving benefits	0
Active plan members	459
Total	534

Benefits provided: Pre-65 benefits only. Please see Appendix B of this report for more details.

Contributions: Smithfield contributions to fund the Plan are currently on a pay-as-you-go basis with additional contributions intended to build the fund for purposes of paying future benefits. Although a funding valuation of the plan was completed during 2016, Smithfield has determined that it will establish an annual employer contribution rate using the valuation as a reference, but not as a definitive requirement.

The plan is funded by Smithfield contributions. For the year ended June 30, 2017, the Town contributed $104,992 to the Plan. Retirees contribute toward the cost of their coverage as described in Appendix A.

Investments

Rate of return: For the year ended June 30, 2017, the annual money-weighted rate of return on investments net of investment expense, was 12.06%. The money-weighted rate of return expresses investment performance, net of investment expense, adjusted for the changing amounts actually invested.

Receivables

Not applicable.

Net OPEB Liability of Smithfield

Components of the net OPEB liability	
Total OPEB liability	$42,130,000
Plan fiduciary net position	2,933,000
Net OPEB liability	39,197,000
Plan fiduciary net position as a percentage of the total OPEB liability	6.96%

Actuarial assumptions

Please see Appendix A of this report for a description of actuarial assumptions.

Schedules of Required Supplementary Information

Schedule of Changes in Net OPEB Liability and Related Ratios		FY 2017
Total OPEB liability		
Service cost	$	2,333,000
Interest		1,198,000
Changes of benefit terms		0
Differences between expected and actual experience		(463,000)
Changes of assumptions		(2,214,000)
Net benefit payments		(1,187,000)
Net change in total OPEB liability	$	(333,000)
Total OPEB liability-beginning	$	42,463,000
Total OPEB liability-ending (a)	$	42,130,000
Plan fiduciary net position		
Contributions-Town	$	1,321,000
Net investment income		304,000
Benefit payments		(1,187,000)
Investment related expense		(25,000)
Other		N/A
Net change in plan fiduciary net position	$	413,000
Plan fiduciary net position-beginning	$	2,520,000
Plan fiduciary net position-ending (b)	$	2,933,000
Town's net OPEB liability-ending (a)-(b)	$	39,197,000
Plan fiduciary net position as a percentage of the total OPEB liability		6.96%
Covered-employee payroll	$	30,222,000
Net OPEB liability as a percentage of covered-employee payroll		129.70%

Notes to Schedule:

A. Benefit changes: None.

B. Changes of assumptions: The discount rate was 2.71% for the beginning of the year liability and 3.14% for the end of the year liability.

Sensitivity of the Net OPEB Liability to Changes in the Discount Rate	1% Decrease 2.14%	Current Discount Rate 3.14%	1% Increase 4.14%
Net OPEB liability	$43,492,000	$39,197,000	$35,385,000

Sensitivity of the Net OPEB Liability to Changes in the Healthcare Cost Trend Rate	1% Decrease	Current Trend Rate	1% Increase
Net OPEB liability	$34,213,000	$39,197,000	$45,134,000

Schedule of Contributions

Schedule of Employer Contributions	2017
Actuarially determined contribution	1,408,000
Contributions related to the actuarially determined contribution	1,513,000
Contribution deficiency (excess)	(105,000)
Covered-employee payroll	$ 30,222,000
Contribution as a percent of payroll	5.0%

Schedule of Investment Returns

	2017
Annual money-weighted rate of return, net of investment expenses	12.13%

Projection of Fiduciary Net Position

As part of our valuation work, we projected benefit payouts and the fiduciary net position of the plan for as long as benefits were expected to be paid to current active and inactive plan participants and their dependents. In projecting the fiduciary net position of the plan, the amount of projected cash flows for contributions from employers was assumed to be equal to the average of contributions from those sources over the last five year period. A portion of the future employer contributions was assumed to be associated with the service cost for future employees. The projected benefit payout and fiduciary net position amounts were compared for each year in the projection period. The plan fiduciary net position is projected to be greater than the benefits to be made in all years until 2019, during which the “crossover point” occurs. During 2019, the plan fiduciary net position will not be sufficient to make all benefit payments for current participants, and will not be sufficient to make any benefit payments thereafter. We determined the single rate of return that, when applied to all projected benefit payments, results in an actuarial present value of projected benefit payments equal to the present value of benefits before the crossover point using the long term asset return assumption of 8.00%, and the present value of benefits after the crossover point using the assumed municipal bond rate of 3.13%. This single equivalent rate of return is 3.14%.

GASB 75 Information

Change in Net OPEB Liability	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB Liability
Net OPEB liability at beginning of year	$ 42,463,000	$ 2,520,000	$ 39,943,000
Service cost	2,333,000		2,333,000
Interest	1,198,000		1,198,000
Changes of benefit terms			
Differences between expected and actual experience	(463,000)		(463,000)
Changes of assumptions	(2,214,000)		(2,214,000)
Contributions-Smithfield		1,321,000	(1,321,000)
Net investment income		304,000	(304,000)
Benefit payments	(1,187,000)	(1,187,000)	0
Investment related administrative expense	0	(25,000)	25,000
Net changes	(333,000)	413,000	1,556,000
Net OPEB liability at end of year	$42,130,000	$2,933,000	$39,197,000

Components of OPEB Expense for the Fiscal Year Ended June 30, 2017	
Service cost	$ 2,333,000
Interest on the total OPEB liability and net cash flow	1,198,000
Projected earnings on OPEB plan investments	(205,000)
Current period effect of benefit changes	0
Current period difference between expected and actual experience	(44,000)
Current period effect of changes in assumptions	(209,000)
Current period difference between projected and actual investment earnings	(20,000)
OPEB plan investment related administrative expenses	25,000
Current period recognition of prior years' deferred outflows of resources	0
Current period recognition of prior years' deferred inflows of resources	0
Total OPEB expense	$ 3,078,000

Following are the details of the recognized and deferred inflows and outflows of resources.

Deferred Outflows/Inflows of Resources		
Deferred Outflows of Resources as of June 30, 2017		
Difference between expected and actual experience	$	0
Changes in assumptions		0
Difference between projected and actual investment earnings		0
Total Deferred Outflows as of June 30, 2017	$	0
Deferred Inflows of Resources as of June 30, 2017		
Difference between expected and actual experience	$	(463,000)
Changes in assumptions		(2,214,000)
Difference between projected and actual investment earnings		(99,000)
Total Deferred Inflows as of June 30, 2017	$	(2,776,000)

The average of the expected remaining service lives of all employees that are provided with benefits through the plan (active and inactive employees) determined at July 1, 2016 (the beginning of the measurement period ended June 30, 2017 is 10.59 years.

Future Years' Recognition of Deferred Outflows/Inflows				
Fiscal Year	FYE 17 Experience (Gain)	FYE 17 Assumption (Gain)	FYE 17 Investment (Gain)	Total
FY 2018	(43,720)	(209,065)	(19,800)	(272,585)
FY 2019	(43,720)	(209,065)	(19,800)	(272,585)
FY 2020	(43,720)	(209,065)	(19,800)	(272,585)
FY 2021	(43,720)	(209,065)	(19,800)	(272,585)
FY 2022	(43,720)	(209,065)	(19,800)	(272,585)
FY 2023	(43,720)	(209,065)	0	(252,785)
FY 2024	(43,720)	(209,065)	0	(252,785)
FY 2025	(43,720)	(209,065)	0	(252,785)
FY 2026	(43,720)	(209,065)	0	(252,785)
FY 2027	(43,720)	(209,065)	0	(252,785)
FY 2028	(25,800)	(123,350)	0	(149,150)

Appendix A

Actuarial Assumptions and Methods

Town of Smithfield, All Groups

Methods

Valuation Date

July 1, 2016. Results are rolled forward to June 30, 2017 for fiscal year end reporting.

Actuarial Cost Method

Entry Age Normal, level percent of pay. Service Costs are attributed through all assumed ages of exit from active service.

Asset Valuation

Market values.

Miscellaneous

The valuation was prepared on an on-going plan basis. This assumption does not necessarily imply that an obligation to continue the plan actually exists.

Economic Assumptions

Discount Rate

The projection of cash flows used to determine the discount rate assumed that Smithfield will contribute at a rate equal to the average of contributions made over the most recent five year period, and that contributions apply first to service cost of current and future plan members and then to past service costs. Based on those assumptions, the OPEB plan's fiduciary net position was projected to be available to make all projected OPEB payments for current active and inactive employees until 2019. After that time, benefit payments for current plan member will be funded on a pay-as-you go basis. The discount rate is the single equivalent rate which results in the same present value as discounting future benefit payments made from assets at the long term expected rate of return and discounting future benefit payments funded on a pay-as-you-go basis on the municipal bond 20-year index rate. The single equivalent interest rate is 3.14%

Long Term Expected Rate of Return

The valuation uses a discount rate of 8.00% per annum, net of investment expenses and including inflation. This is the long term rate of return assumption on plan assets. A cash flow analysis

indicates that the assets will be sufficient to pay all future benefit payments for current participants until 2019 based on the assumed contribution policy.

The long term rate of return is based on the target asset allocation in the Fund's investment policy and was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. Best estimates of arithmetic rates of return for each major asset class included in the System's target asset allocation are summarized below:

Asset Class	Target Allocation	Long-Term Expected Real Rate of Return
U.S. Equity	48.3%	8.00%
Non-U.S. Equity	20.7%	8.60%
U.S. Aggregate Bonds	9.0%	3.60%
Intermediate-Term Credit	5.4%	4.20%
Short-Term Credit	3.6%	3.90%
Intermediate-Term TIPS	5.0%	2.70%
REITs	8.0%	6.80%

Nominal long-term expected rates of return for these asset classes are equal to the sum of the above expected long-term real rates and the expected long-term inflation rate of 3.0%.

Municipal Bond 20-year Index Rate

3.13% based on the S&P Municipal Bond 20 Year High Grade Rate Index as of July 1, 2017.

Consumer Price Index

3.00%

Salary Increases

Salary increases vary by years of service as follows:

Years of Service	Town Employees	Police and Fire Employees	School Employees
0	7.50%	14.00%	13.50%
1	6.50%	13.00%	12.50%
2	6.25%	11.00%	9.75%
3	6.00%	8.00%	9.00%
4	5.75%	6.50%	8.50%
5	5.50%	7.00%	8.50%
6	4.75%	4.50%	8.00%
7	4.25%	4.50%	7.75%
8	4.00%	4.00%	7.50%
9	4.00%	4.00%	7.50%
10+	3.75%	4.00%	3.50%

Assumed Trend

The combined effect of price inflation and utilization on gross eligible medical and prescription drug charges is according to the table below. The initial trend rate was developed using our National Health Care Trend Survey. The survey gathers information of trend expectations for the coming year from various insurers and pharmacy benefit managers. These trends are broken out by drug and medical, as well as type of coverage (e.g. PPO, HMO, POS). We selected plans that most closely match Smithfield's benefits to set the initial trend. The ultimate trend is developed based on a building block approach which considers CPI, GDP, and Technology growth. The healthcare cost trend rates are shown below:

Fiscal Year	Inflation Rate
2017	8.50%
2018	8.00%
2019	7.50%
2020	7.00%
2021	6.50%
2022	6.00%
2023	5.50%
2024	5.00%
2025+	4.50%

Retiree contribution trend: Same as medical trend except that contributions for capped retirees will increase at a faster rate due to the cap.

Health Care Claim Cost

Because the plans are experience rated and limited claims information was available, the assumed per capita costs are based on reported premiums as shown in Section III. The costs were adjusted to age 65 and then adjusted to age-specific rates using the age-based morbidity factors discussed further below. These costs are assumed to include any associated administrative expenses.

Plan	Individual @ Age 65
Police	$19,408
Fire	$19,539
Town	$18,436
School – Deductible (Co-Ins 100/80)	$12,265
School – Standard	$13,533
School - Classic	$16,133

Age Related Morbidity

Per capita costs are adjusted to reflect expected cost differences due to age and gender. Age morbidity factors for pre-Medicare morbidity were developed from "Health Care Costs—From Birth to Death" sponsored by the Society of Actuaries and prepared by Dale H. Yamamoto (May 2013)[1]. Morbidity factors at sample ages are shown below:

Age	Male	Female
50	0.4612	0.5736
55	0.6085	0.6667
60	0.7829	0.7791
65	1.0000	0.9438

Morbidity is not applied to dental rates.

Excise Tax on High-Cost Employer Health Plans (aka Cadillac Tax) - Effective 1/1/2020 (initially expected 2018)

The excise tax is not reflected since we have ruled it to be non-material due to its minor impact on the liabilities.

[1] https://www.soa.org/resources/research-reports/2013/research-health-care-birth-death/

Demographic Assumptions

Basis for Assumptions

The retirement and termination decrements and mortality employed in the current valuation were based on the 2014 GRS Experience Study covering the period from July 1, 2007, through June 30, 2013. The disability decrements remain the same as the July 1, 2016 valuation report as the updated disability decrements in the GRS Study stated to have de minims impact on liabilities.

Mortality

For healthy lives the RP-2014 Combined Healthy Mortality Table, projected on a fully generational basis by Mortality Improvement Scale MP-2016

For existing disabled lives, the RP-2014 Disabled Retiree Mortality Table, projected on a fully generational basis by Mortality Improvement Scale MP-2016.

Normal Retirement

For town employees: A flat 25% per year retirement probability for members eligible for unreduced retirement. A 50% retirement probability at first eligibility will be only applied if they have reached age 65 or with at least 25 years of service.

For police and fire employees: Unisex, service based rates are used for police and fire. All members are assumed to retire upon reaching age 65 with at least ten years of service. Rates vary based on years of services as follows:

	Retirement Rate	
Service	With the Optional 20-year retirement election	Without the Optional 20-year retirement election
20	12%	
21	10%	
22	10%	
23	10%	
24	12%	
25	14%	50%
26	16%	16%
27	18%	18%
28	20%	20%
29	20%	20%
30+	35%	35%

For Teachers: A flat 25% per year retirement probability for members eligible for unreduced retirement. A 60% retirement probability at first eligibility will be only applied if they have reached age 65 or with at least 25 years of service.

Disability Rates

Disability assumptions are same as the June 30, 2016 valuation report. For teachers disability rates are based on the Teachers retirement rate table published in the 2010 ERS Experience Study.

For non-teacher general employees disability rates are based on the General Employees' disability rate table published in the 2010 MERS Experience Study.

Ordinary disability rates were assumed to continue for members eligible for retirement.

	ERSRI General		Teachers		Fire Hancock (based on years of service)	
Service	Male	Female	Male	Male	<20	20 +
20	0.09%	0.04%	0.03%	0.03%	0.30%	0.26%
25	0.09%	0.04%	0.03%	0.03%	0.30%	0.26%
30	0.11%	0.04%	0.03%	0.03%	0.39%	0.33%
35	0.14%	0.06%	0.04%	0.04%	0.51%	0.44%
40	0.21%	0.08%	0.06%	0.06%	0.77%	0.66%
45	0.34%	0.14%	0.10%	0.10%	1.26%	1.08%
50	0.58%	0.23%	0.18%	0.18%	2.12%	1.82%
55	0.96%	0.38%	0.29%	0.29%	2.12%	1.82%
60	1.34%	0.54%	0.41%	0.41%	2.12%	1.82%

Termination Rates

Termination rates for town employees, police and fire employees, and school employees are as follows:

Years of Service	Town Employees	Police and Fire Employees	School Employees
0	17.50%	10.00%	18.00%
1	11.88%	4.73%	12.00%
2	10.14%	3.69%	8.00%
3	8.61%	3.08%	6.48%
4	7.29%	2.65%	4.82%
5	6.15%	2.32%	3.83%
6	5.18%	2.04%	3.17%
7	4.36%	1.81%	2.70%
8	3.69%	1.61%	2.36%
9	3.14%	1.43%	2.09%
10	2.71%	1.28%	1.87%
11	2.37%	1.13%	1.70%
12	2.13%	1.00%	1.55%
13	1.95%	0.88%	1.43%
14	1.83%	0.77%	1.32%
15	1.75%	0.67%	1.23%
16	1.70%	0.57%	1.15%
17	1.66%	0.48%	1.08%
18	1.62%	0.39%	1.02%
19	1.57%	0.00%	0.96%
20	1.49%	0.00%	0.91%
21	1.36%	0.00%	0.87%
22	1.18%	0.00%	0.83%
23	0.92%	0.00%	0.79%
24	0.58%	0.00%	0.76%
25+	0.00%	0.00%	0.00%

Participation Rate

Based on experience for similar clients, for non-School non-union employees hired after December 31, 1988, 50% for all future retirees. For all other non-School employees, 100% for all future retirees. For School employees, 100% for future retirees expecting to receive full subsidy and 85% for future retirees without full subsidy. Future School retirees are expected to elect same medical plan coverage as their current active medical plan.

Dependents

Based on experience for similar clients, 80% of male employees and 60% of female employees are assumed to have a covered spouse at retirement. Wives are assumed to be three years younger than their husbands.

Appendix B

Summary of Plan Provisions

Plan sponsor

Smithfield

Plan name

Smithfield Postretirement Benefits Plan

Eligibility

Group	Eligibility
Town (except Police and Fire)	
Service Retirement	Age 58 with 20 years of service
Disability Retirement	No service requirement
Police and Fire	
Service Retirement	20 years of service
Disability Retirement	No service requirement
School	
Hired before 6/20/1989	Age 60 with 15 years of service
Hired on or after 6/20/1989	Age 60 with 20 years of service; or 28 years of service with at least 15 years with Smithfield

Note: Smithfield offers pre-65 benefits only.

Cost Sharing

Group	Contribution Structure
Town	
Non-Union hired after 12/31/1988	Participants and spouses contribute 100%.
Other Town employees	Participants and spouses are non-contributory
Police and Fire	Participants and spouses are non-contributory
School	
Hired before 6/20/1989	If either (1) age 60 with 20 years of service; or (2) 28 years of service with at least 15 years with Smithfield, participant and spouse are non contributory. Otherwise (i.e., 60/15 but not 60/20, or service < 28), plan contribution is frozen at the date of retirement.
Hired on or after 6/20/1989 but before 7/1/1992	If 28 years of service with at least 15 years with Smithfield, participant and spouse are non contributory Otherwise (i.e., 60/20 and service < 28), 50% contribution
Hired on or after 7/1/1992	Plan contributes a maximum of $5,000 annually

Summary of benefits and coverages:

See Appendix F for further details.

Contribution rates:

Benefits are available to employees and retirees through a number of Plans depending on the contract negotiated. The following are the current annual medical premium rates:

Annual Post Retirement Premiums effective July 1, 2017*		
Plans - Medical	**Individual**	**Family**
Police	$ 9,454	$ 23,856
Fire	$ 9,518	$ 24,110
Town	$ 8,981	$ 22,660
Classic - School	$ 9,939	$ 25,090
HealthMate - School	$ 8,337	$ 21,394
Healthmate 100/80 - School	$ 7,556	$ 19,387

* We backed out one year of assumed trend to bring these premiums to the valuation date (i.e., 7/1/2016)

The following are the current annual dental premium rates:

Annual Post Retirement Premiums effective July 1, 2017*		
Plans - Dental	**Individual**	**Family**
Police	$ 430	$ 1,070
Fire	$ 430	$ 1,070
Town	$ 430	$ 1,037
Classic - School	$ 446	$ 1,084
HealthMate - School	$ 446	$ 1,084
Healthmate 100/80 - School	$ 446	$ 1,084

* We backed out one year of assumed trend to bring these premiums to the valuation date (i.e., 7/1/2016)

Participant and Spousal Coverage

Participant and spouses are covered until age 65.

Disabled Retiree Coverage

Coverage is provided for the first 30 months of disability, and continues afterwards if the participant is eligible for Medicare. If not eligible for Medicare after 30 months of disability, coverage ceases.

Life Insurance Benefits:

None

Appendix C

Summary of Participant Data

The following table shows a distribution of age, service, and salary for all active employees as of the valuation date:

	Completed Years of Service								
Attained Age	<5	5 - 9	10 - 14	15 - 19	20 - 24	25 - 29	30 - 34	35+	Total
Under 25	7	0	0	0	0	0	0	0	7
25 to 29	23	5	0	0	0	0	0	0	28
30 to 34	15	21	14	0	0	0	0	0	50
35 to 39	6	14	32	8	0	0	0	0	60
40 to 44	8	7	22	30	2	0	0	0	69
45 to 49	11	10	15	18	13	3	0	0	70
50 to 54	7	13	17	10	4	22	5	0	78
55 to 59	8	9	11	18	9	6	2	0	63
60 to 64	3	2	7	8	6	5	0	0	31
65 to 69	1	0	0	1	1	0	0	0	3
70 & up	0	0	0	0	0	0	0	0	0
Total	89	81	118	93	35	36	7	0	459

The retiree, survivor, and disabled counts are summarized below:

	Count	Avg. Age
Retirees < 65	75	58.2
Retirees >= 65	0	0.0

Covered spouse counts are summarized below:

	Count	Avg Age
Spouses < 65	51	56.8
Spouses >= 65	0	0.0
Total Spouses	51	56.8

Appendix D

Health Care Reform

Health care delivery is going through a revolution due to the enactment of Health Care Reform. The Patient Protection and Affordable Care Act (ACA), was signed March 23, 2010, with further changes enacted by the Health Care and Education Reconciliation Act (HCERA), signed March 30, 2010. This valuation uses various assumptions that were modified based on considerations under Health Care Reform legislation. This Section discusses particular legislative changes that were reflected in our assumptions. We have not identified any other specific provision of Health Care Reform that would be expected to have a significant impact on the measured obligation. As additional guidance on the legislation is issued, we continue to monitor any potential impacts.

Removal of Lifetime Maximum – Effective 1/1/2011

Smithfield provides retirees medical coverage under a retiree only arrangement, so that the provision eliminating lifetime maximums does not apply to the benefits described herein.

Expansion of Child Coverage to Age 26 - Effective 1/1/2011

Smithfield provides retirees medical coverage under a retiree only arrangement, so that the provision allowing the enrollment of adult children does not apply to Smithfield's benefits.

Medicare Part D Subsidy - Shrinking Medicare Prescription Drug "Donut Hole"- Starting 1/1/2011

Since Smithfield medical coverage ends at age 65, the phase in of the donut hole benefits had no impact on this valuation.

Other Revenue Raisers

The Health Care Reform includes a variety of other revenue raisers that involve additional costs on providers (such as medical device manufacturers) and insurers. We considered these factors when developing the trend assumptions.

Other

We have not identified any other specific provision of health care reform that would be expected to have a significant impact on the measured obligation. As additional guidance on the legislation is issued, we will continue to monitor any potential impacts.

Health Care Reform Repeal

The new Republican leadership in Washington has clearly announced their intention to repeal ACA. As one of his first acts in office, President Trump issued an executive order that states that federal agencies can grant waivers, exemptions and delays of "Obamacare" provisions that would impose costs on states or individuals. On February 15, CMS issued proposed rules that are intended to minimize adverse selection, but which might disrupt the fragile balance of the healthcare exchanges. We can expect more information about what is being altered. As of the writing of this report, we have not identified any action that has already formally been adopted that would be expected to have significant impact on the measured obligation.

Appendix E

Summary of Key Accounting Terms

Actuarially determined contribution

A target or recommended contribution to a defined benefit OPEB plan for the reporting period, determined in conformity with Actuarial Standards of Practice based on the most recent measurement available when the contribution for the reporting period was adopted.

Actuarial present value of projected benefit payments

Projected benefit payments discounted to reflect the expected effects of the time value (present value) of money and the probabilities of payment.

Actuarial valuation

The determination, as of a point in time (the actuarial valuation date), of the service cost, total OPEB liability, and related actuarial present value of projected benefit payments for OPEB performed in conformity with Actuarial Standards of Practice unless otherwise specified by the GASB.

Actuarial valuation date

The date as of which an actuarial valuation is performed.

Ad hoc postemployment benefit changes

Postemployment benefit changes that require a decision to grant by the authority responsible for making such decisions.

Automatic hoc postemployment benefit changes

Postemployment benefit changes that occur without a requirement for a decision to grand by a responsible authority.

Covered-employee payroll

The payroll for employees that are provided with OPEB through the OPEB plan.

Discount rate

The single rate of return that, when applied to all projected benefit payments, results in an actuarial present value of projected benefit payments equal to the total of the following:

a. The actuarial present value of benefit payments projected to be made in future periods in which (1) the amount of the OPEB plan's fiduciary net position is projected (under the requirements of this Statement) to be greater than the benefit payments that are projected to be made in that period and (2) OPEB plan assets up to that point are expected to be invested using a strategy to achieve the long-term expected rate of return, calculated using the long-term expected rate of return on OPEB plan investments

b. The actuarial present value of projected benefit payments not included in (a), calculated using a yield or index rate for 20-year, tax-exempt general obligation municipal bonds with an average rating of AA/Aa or higher (or equivalent quality on another rating scale).

Entry age actuarial cost method

A method under which the actuarial present value of the projected benefits of each individual included in an actuarial valuation is allocated on a level basis over the earnings or service of the individual between entry age and assumed exit age(s). The portion of this actuarial present value allocated to a valuation year is called the normal cost. The portion of this actuarial present value not provided for at a valuation date by the actuarial present value of future normal costs is called the Actuarial accrued liability.

Healthcare cost trend rates

The rates of change in per capita health claims costs over time as a result of factors such as medical inflation, utilization of healthcare services, plan design, and technological developments. Inactive employees Individuals no longer employed by an employer in the OP Measurement period. The period between the prior and the current measurement dates.

Net OPEB liability

The liability of employers and non-employer contributing entities to employees for benefits provided through a defined benefit OPEB plan that is administered through a trust that meets the criteria in paragraph 4 of this Statement. Other postemployment benefits (OPEB) Benefits (such as death benefits, life insurance, disability, and long-term care) that are paid in the period after employment and that are provided separately from a pension plan, as well as healthcare benefits paid in the period after employment, regardless of the manner in which they are provided. OPEB does not include termination benefits or termination payments for sick leave.

Projected benefit payments

All benefits (including refunds of employee contributions) estimated to be payable through the OPEB plan (including amounts to be paid by employers or non-employer contributing entities as the benefits come due) to current active and inactive employees as a result of their past service and their expected future service.

Real rate of return

The rate of return on an investment after adjustment to eliminate inflation.

Service costs

The portions of the actuarial present value of projected benefit payments that are attributed to valuation years.

Total OPEB liability

The portion of the actuarial present value of projected benefit payments that is attributed to past periods of employee service.

Appendix F

Summaries of Benefits and Coverage for Retiree Health Plans

POLICE AND FIRE RETIREES

BCBSRI HealthMate Coast-To-Coast

The 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 care 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 1-800-639-2227 or (401) 459-5000 or TDD 711 or visit us at www.BCBSRI.com. 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 call 1-800-639-2227 or (401) 459-5000 or TDD 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Out-of-Network providers **$200** for an individual plan / **$600** for a family plan.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency room care, emergency medical transportation and specialty drugs	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For In Network providers **$6,350** for an individual plan / **$12,700** for a family plan. For Out-of-Network providers **$6,350** for an individual plan / **$12,700** for a family plan.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.BCBSRI.com or by calling 1-800-639-2227 or (401) 459-5000 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		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	$10 copay/office visit	$10 copay/office visit plus 20% coinsurance	None
	Specialist visit	$10 copay/office visit	$10 copay/office visit plus 20% coinsurance	Chiropractic Services are limited to 12 visit(s) per year, $15 copay for allergy and dermatology office visits
	Preventive care/screening/ immunization	No charge	$10 copay plus 20% coinsurance	Member liability for In Network and Out-of-Network is based on services received; You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. For additional details, please see your plan documents or visit www.BCBSRI.com/providers/policies
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Preauthorization is recommended for certain services.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.BCBSRI.com.	Tier 1/Generic drugs	$5 copay/prescription (retail) $10 copay/prescription (mail-order)	Not covered	No charge for certain preventive drugs; Preauthorization is required for certain drugs. Infertility drugs: 20% coinsurance; deductible does not apply
	Tier 2/Preferred brand drugs	$10 copay/prescription (retail) $20 copay/prescription (mail-order)	Not covered	
	Tier 3/Non-preferred brand drugs	$10 copay/prescription (retail) $20 copay/prescription (mail-order)	Not covered	
	Tier 4/Specialty drugs	$10 copay/prescription (specialty pharmacy only)	50% coinsurance; deductible does not apply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Preauthorization is recommended.
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$25 copay/visit	$25 copay/visit; deductible does not apply	Emergency room: Copay waived if admitted Urgent Care: Visit only; additional services received are subject to additional out-of-pocket costs.
	Emergency medical transportation	$50 copay/trip	$50 copay/trip; deductible does not apply	
	Urgent care	$10 copay/urgent care center visit	$10 copay/urgent care center visit; plus 20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	45 day limit at an inpatient rehabilitation facility; Preauthorization is recommended
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/office visit No charge /outpatient services;	$10 copay/office visit plus 20% coinsurance 20% coinsurance/outpatient services	Preauthorization is recommended for certain services.
	Inpatient services	No charge	20% coinsurance	
If you are pregnant	Office visits	$10 copay/office visit	$10 copay/office visit plus 20% coinsurance	Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is recommended.
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	
If you need help	Home health care	No charge	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
recovering or have other special health needs	Rehabilitation services	20% coinsurance	20% coinsurance	Includes Physical, Occupational and Speech Therapy. Physical and Occupational. Speech Therapy preauthorization is recommended for all visits. No charge for services to treat autism spectrum disorder and preauthorization is not required.
	Habilitation services	20% coinsurance	20% coinsurance	
	Skilled nursing care	No charge	20% coinsurance	Preauthorization is recommended. Custodial Care is not covered.
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization is recommended for certain services.
	Hospice services	No charge	20% coinsurance	Preauthorization is recommended.
If your child needs dental or eye care	Children's eye exam	$10 copay/office visit	$10 copay/office visit plus 20% coinsurance	Limited to one routine eye exam per year.
	Children's glasses	100% of provider charge	100% of provider charge	Limited to $100 per member age 0 - 18 per occurrence/$100 per member age 19 and over per year for prescription glasses (frames and/or lenses) or contact lenses.
	Children's dental check-up	Not covered	Not covered	None

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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up, child
- Long-term care
- Routine foot care unless to treat a systemic condition
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery • Chiropractic care • Hearing aids	• Infertility treatment • Most coverage provided outside the United States. Contact Customer Service for more information.	• Private-duty nursing • Routine eye care (Adult)

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 us and those agencies is: the plan at 1-800-639-2227 or (401) 459-5000 or TDD 711, state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: contact the plan at 1-800-639-2227 or (401) 459-5000 or TDD 711. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact your state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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:
Para obtener asistencia en Español, llame al 1-800-639-2227.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-639-2227.
如果需要中文的帮助，请拨打这个号码1-800-639-2227.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-639-2227.

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

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)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$100**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$390
Coinsurance	$350
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$800**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$180
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$230**

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

TOWN/MUNICIPAL RETIREES

BCBSRI HealthMate Coast-To-Coast

The 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 care 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 1-800-639-2227 or (401) 459-5000 or TDD 711 or visit us at www.BCBSRI.com. 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 call 1-800-639-2227 or (401) 459-5000 or TDD 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Out-of-Network: **$200** individual / **$600** family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency room care, emergency medical transportation and some specialty drugs	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: **$6,350** individual, **$12,700** family Out-of-Network: **$6,350** per individual, **$12,700** family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.BCBSRI.com or by calling 1-800-639-2227 or (401) 459-5000 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		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	$15 copay/office visit	$15 copay/office visit plus 20% coinsurance	None
	Specialist visit	$25 copay/office visit	$25 copay/office visit plus 20% coinsurance	Chiropractic Services are limited to 12 visit(s) per year.
	Preventive care/screening/ immunization	No charge	$25 copay/office visit plus 20% coinsurance	Member liability for In Network and Out-of-Network is based on services received; You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. For additional details, please see your plan documents or visit www.BCBSRI.com/providers/policies
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Preauthorization is recommended for certain services.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.BCBSRI.com.	Tier 1/Generic drugs	$5 copay/prescription (retail) $10 copay/prescription (mail-order)	Not covered	No charge for certain preventive drugs; Preauthorization is required for certain drugs. Infertility drugs: 20% coinsurance; deductible does not apply
	Tier 2/Preferred brand drugs	$15 copay/prescription (retail) $30 copay/prescription (mail-order)	Not covered	
	Tier 3/Non-preferred brand drugs	$30 copay/prescription (retail) $60 copay/prescription (mail-order)	Not covered	
	Tier 4/Specialty drugs	$30 copay/prescription (specialty pharmacy only)	50% coinsurance; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Preauthorization is recommended.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit; deductible does not apply	Emergency room: Copay waived if admitted Urgent Care: Visit only; additional services received are subject to additional out-of-pocket costs.
	Emergency medical transportation	$50 copay/trip	$50 copay/trip; deductible does not apply	
	Urgent care	$50 copay/urgent care center visit	$50 copay/urgent care center visit; plus 20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	45 day limit at an inpatient rehabilitation facility; Preauthorization is recommended
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit No charge /outpatient services	$25 copay/office visit plus 20% coinsurance 20% coinsurance/outpatient services	Preauthorization is recommended for certain services.
	Inpatient services	No charge	20% coinsurance	
If you are pregnant	Office visits	$25 copay/office visit	$25 copay/office visit plus 20% coinsurance	Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is recommended.
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	None
	Rehabilitation services	20% coinsurance	20% coinsurance	Includes Physical, Occupational and Speech Therapy. Physical and Occupational. Speech Therapy preauthorization is recommended for all visits. No Charge for services to treat autism spectrum disorder and preauthorization is not required
	Habilitation services	20% coinsurance	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	No charge	20% coinsurance	Preauthorization is recommended. Custodial Care is not covered.
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization is recommended for certain services.
	Hospice services	No charge	20% coinsurance	Preauthorization is recommended.
If your child needs dental or eye care	Children's eye exam	$25 copay/office visit	$25 copay/office visit plus 20% coinsurance	Limited to one routine eye exam per year.
	Children's glasses	100% of provider charge	100% of provider charge	Limited to $100 per member age 0 - 18 per occurrence/$100 per member age 19 and over per year for prescription glasses (frames and/or lenses) or contact lenses.
	Children's dental check-up	Not covered	Not covered	None

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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up, child
- Long-term care
- Routine foot care unless to treat a systemic condition
- Weight loss programs

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

- Bariatric Surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Most coverage provided outside the United States. Contact Customer Service for more information.
- Private-duty nursing
- Routine eye care (Adult)

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 us and those agencies is: the plan at 1-800-639-2227 or (401) 459-5000 or TDD 711, state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: contact the plan at 1-800-639-2227 or (401) 459-5000 or TDD 711. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact your state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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:
Para obtener asistencia en Español, llame al 1-800-639-2227.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-639-2227.
如果需要中文的帮助，请拨打这个号码1-800-639-2227.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-639-2227.

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

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)

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$230
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$290**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$620
Coinsurance	$350
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,030**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$230
Coinsurance	$50
What isn't covered	
Limits or exclusions	$00
The total Mia would pay is	**$280**

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

SCHOOL RETIREES

BCBSRI Classic Blue

The 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 care 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 1-800-639-2227 or (401) 459-5000 or TDD 711 or visit us at www.BCBSRI.com. 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 call 1-800-639-2227 or (401) 459-5000 or TDD 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$200** individual / **$400** per member for a family plan. Out-of-Network: **$200** individual / **$400** per member for a family plan combined with In-Network deductible.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible
Are there services covered before you meet your deductible?	Yes. Preventive services, services with a fixed dollar copay, prescription drugs, diagnostic testing, imaging services, infertility services, inpatient services and most outpatient services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. For In Network providers **$6,350** for an individual plan **/ $12,700** for a family plan. For Out-of-Network providers **$6,350** for an individual plan **/ $12,700** for a family plan combined with in-network out-of-pocket limit.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit
Will you pay less if you use a network provider?	Yes. See www.BCBSRI.com or by calling 1-800-639-2227 or (401) 459-5000 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		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% coinsurance	20% coinsurance	None
	Specialist visit	20% coinsurance	20% coinsurance	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	20% coinsurance	Member liability for In Network and Out-of-Network is based on services received; You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. For additional details, please see your plan documents or visit www.BCBSRI.com/providers/policies
If you have a test	Diagnostic test (x-ray, blood work)	No charge; deductible does not apply	No charge; deductible does not apply	Preauthorization is recommended for certain services.
	Imaging (CT/PET scans, MRIs)	No charge; deductible does not apply	No charge; deductible does not apply	
If you need drugs to treat your illness or condition	Tier 1/Generic drugs	20% coinsurance /prescription (retail and mail order); deductible does not apply	Not covered	No charge for certain preventive drugs Preauthorization is required for certain drugs; Infertility drugs: 20% coinsurance; deductible does not apply
	Tier 2/Preferred brand drugs	20% coinsurance /prescription (retail and mail order); deductible does not apply	Not covered	
	Tier3/Non-preferred brand drugs	20% coinsurance /prescription (retail and mail order); deductible does not apply	Not covered	
	Tier 4/Specialty drugs	20% coinsurance /prescription (specialty pharmacy only); deductible does not apply	50% coinsurance; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge; deductible does not apply	No charge; deductible does not apply	Preauthorization is recommended.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No charge; deductible does not apply	No charge; deductible does not apply	None
If you need immediate medical attention	Emergency room care	No charge; deductible does not apply	No charge; deductible does not apply	None
	Emergency medical transportation	$50 copay/trip; deductible does not apply	$50 copay/trip; deductible does not apply	
	Urgent care	20% coinsurance/urgent care center visit	20% coinsurance/urgent care center visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge; deductible does not apply	No charge; deductible does not apply	45 day at an inpatient rehabilitation facility; Preauthorization is recommended
	Physician/surgeon fees	No charge; deductible does not apply	No charge; deductible does not apply	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance/office visit No charge/outpatient services; deductible does not apply	20% coinsurance/office visit No charge/outpatient services; deductible does not apply	Preauthorization is recommended for certain services.
	Inpatient services	No charge; deductible does not apply	No charge; deductible does not apply	
If you are pregnant	Office visits	20% coinsurance/office visit	20% coinsurance/office visit	Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is recommended.
	Childbirth/delivery professional services	No charge; deductible does not apply	No charge; deductible does not apply	
	Childbirth/delivery facility services	No charge; deductible does not apply	No charge; deductible does not apply	
If you need help recovering or have other special health needs	Home health care	No charge; deductible does not apply	No charge; deductible does not apply	None
	Rehabilitation services	20% coinsurance	20% coinsurance	Includes Physical, Occupational and Speech Therapy. Physical and Occupational. Speech Therapy preauthorization is recommended for all visits. No Charge for services to treat autism spectrum disorder and preauthorization is not required
	Habilitation services	20% coinsurance	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	No charge; deductible does not apply	No charge; deductible does not apply	Preauthorization is recommended. Custodial Care is not covered.
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization is recommended for certain services.
	Hospice services	No charge; deductible does not apply	No charge; deductible does not apply	Preauthorization is recommended.
If your child needs dental or eye care	Children's eye exam	$10 copay/office visit	$10 copay/office visit	Limited to one routine eye exam per year; Medically necessary exams are covered at 20% coinsurance after deductible
	Children's glasses	100% of provider charge	100% of provider charge	Limited to $50 per member age 0 - 18 per occurrence/$50 per member age 19 and over per year for prescription glasses (frames and/or lenses) or contact lenses.
	Children's dental check-up	Not covered	Not covered	None

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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up, child
- Long-term care
- Routine foot care unless to treat a systemic condition
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery • Chiropractic care • Hearing aids	• Infertility treatment • Most coverage provided outside the United States. Contact Customer Service for more information. • Private-duty nursing	• Routine eye care (Adult)

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 us and those agencies is: the plan at 1-800-639-2227 or (401) 459-5000 or TDD 711, state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: contact the plan at 1-800-639-2227 or (401) 459-5000 or TDD 711. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact your state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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:
Para obtener asistencia en Español, llame al 1-800-639-2227.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-639-2227.
如果需要中文的帮助，请拨打这个号码1-800-639-2227.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-639-2227.

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

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)

The plan's overall deductible	$200
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$160
Copayments	$0
Coinsurance	$50
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$270**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$200
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$1,410
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,670**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$200
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$150
Coinsurance	$110
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$460**

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

SCHOOL RETIREES

BCBSRI HealthMate Coast-To-Coast Standard

The 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 care 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 1-800-639-2227 or (401) 459-5000 or TDD 711 or visit us at www.BCBSRI.com. 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 call 1-800-639-2227 or (401) 459-5000 or TDD 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Out-of-Network: **$200** individual / **$600** per member for a family plan	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency room care, emergency medical transportation and some specialty drugs	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. For In Network providers **$6,350** for an individual plan / **$12,700** for a family plan. For Out-of-Network providers **$6,350** for an individual plan / **$12,700** for a family plan.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.BCBSRI.com or by calling 1-800-639-2227 or (401) 459-5000 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		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	$10 copay/office visit	$10 copay/office visit plus 20% coinsurance	None
	Specialist visit	$10 copay/office visit	$10 copay/office visit plus 20% coinsurance	Chiropractic Services are limited to 12 visits per year; $15 copay for allergy and dermatology office visits
	Preventive care/screening/ immunization	No charge	$10 copay/office visit plus 20% coinsurance	Member liability for In Network and Out-of-Network is based on services received; You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. For additional details, please see your plan documents or visit www.BCBSRI.com/providers/policies
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Preauthorization is recommended for certain services.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.BCBSRI.com.	Tier 1/Generic drugs	$10 copay/prescription (retail) $25 copay/prescription (mail-order)	Not covered	No charge for certain preventive drugs Preauthorization is required for certain drugs Infertility drugs: 20% coinsurance; deductible does not apply
	Tier 2/Preferred brand drugs	$25 copay/prescription (retail) $62.50 copay/prescription (mail-order)	Not covered	
	Tier 3/Non-preferred brand drugs	$40 copay/prescription (retail) $100 copay/prescription (mail-order)	Not covered	
	Tier 4/Specialty drugs	$40 copay/prescription (retail); (specialty pharmacy only)	50% coinsurance; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Preauthorization is recommended;

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay/visit; deductible does not apply	$100 copay/visit; deductible does not apply	Copay waived if admitted Urgent Care: Visit only; additional services received are subject to additional out-of-pocket costs.
	Emergency medical transportation	$50 copay/trip; deductible does not apply	$50 copay/trip; deductible does not apply	
	Urgent care	$35 copay/urgent care center visit	$35 copay/urgent care center visit; plus 20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	45 day limit at an inpatient rehabilitation facility; Preauthorization is recommended
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/office visit No charge /outpatient services	$10 copay/office visit plus 20% coinsurance 20% coinsurance/outpatient services	Preauthorization is recommended for certain services.
	Inpatient services	No charge	20% coinsurance	
If you are pregnant	Office visits	$10 copay/office visit	$10 copay/office visit plus 20% coinsurance	Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is recommended.
	Childbirth/delivery professional services	No charge	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	No charge	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	None
	Rehabilitation services	20% coinsurance	20% coinsurance	Includes Physical, Occupational and Speech Therapy. Physical and Occupational. Speech Therapy preauthorization is recommended for all visits. No Charge for services to treat autism spectrum disorder and preauthorization is not required
	Habilitation services	20% coinsurance	20% coinsurance	
	Skilled nursing care	No charge	20% coinsurance	Preauthorization is recommended. Custodial Care is not covered.
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization is recommended for certain services.
	Hospice services	No charge	20% coinsurance	Preauthorization is recommended.
If your child needs dental or eye care	Children's eye exam	$10 copay/office visit	$10 copay/office visit plus 20% coinsurance	Limited to one routine eye exam per year.
	Children's glasses	100% of provider charge	100% of provider charge	Limited to $50 per member age 0 - 18 per occurrence/$50 per member age 19 and over per year for prescription glasses (frames and/or lenses) or contact lenses.
	Children's dental check-up	Not covered	Not covered	None

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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up, child
- Long-term care
- Routine foot care unless to treat a systemic condition
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery • Chiropractic care • Hearing aids	• Infertility treatment • Most coverage provided outside the United States. Contact Customer Service for more information. • Private-duty nursing	• Routine eye care (Adult) • Acupuncture

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 us and those agencies is: the plan at 1-800-639-2227 or (401) 459-5000 or TDD 711, state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: contact the plan at 1-800-639-2227 or (401) 459-5000 or TDD 711. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact your state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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:
Para obtener asistencia en Español, llame al 1-800-639-2227.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-639-2227.
如果需要中文的帮助，请拨打这个号码1-800-639-2227.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-639-2227.

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

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)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$120**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$740
Coinsurance	$350
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,150**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$180
Coinsurance	$50
What isn't covered	
Limits or exclusions	$00
The total Mia would pay is	**$230**

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

Custom_MHM01057_R4000521_VR000024_20170701_20180630_PHMC2C_C 196_01_V

SCHOOL RETIREES

BCBSRI HealthMate Coast-To-Coast Deductible (Co-Ins 100/80)

The 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 care 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 1-800-639-2227 or (401) 459-5000 or TDD 711 or visit us at www.BCBSRI.com. 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 call 1-800-639-2227 or (401) 459-5000 or TDD 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In Network providers **$500** for an individual plan / **$1,000** per member for a family plan. For Out-of-Network providers **$500** for an individual plan / **$1,000** per member for a family plan.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible
Are there services covered before you meet your deductible?	Yes. Preventive services, services with a fixed dollar copay, prescription drugs, diagnostic testing, imaging services and outpatient mental health services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services
What is the out-of-pocket limit for this plan?	Yes. For In Network providers **$6,350** for an individual plan / **$12,700** for a family plan. For Out-of-Network providers **$6,350** for an individual plan / **$12,700** for a family plan.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.BCBSRI.com or by calling 1-800-639-2227 or (401) 459-5000 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		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	$15 copay/office visit; deductible does not apply	$15 copay/office plus 20% coinsurance	None
	Specialist visit	$25 copay/office visit; deductible does not apply	$25 copay/office plus 20% coinsurance	Chiropractic Services are limited to 12 visit(s) per year
	Preventive care/screening/ immunization	No charge; deductible does not apply	$25 copay/office plus 20% coinsurance	Member liability for In Network and Out-of-Network is based on services received; You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. For additional details, please see your plan documents or visit www.BCBSRI.com/providers/policies
If you have a test	Diagnostic test (x-ray, blood work)	No charge; deductible does not apply	20% coinsurance	Preauthorization is recommended for certain services
	Imaging (CT/PET scans, MRIs)	No charge; deductible does not apply	20% coinsurance	
If you need drugs to treat your illness or condition	Tier 1/Generic drugs	$10 copay /prescription (retail) $25 copay /prescription (mail-order); deductible does not apply	Not covered	No charge for certain preventive drugs Preauthorization is required for certain drugs Infertility drugs: 20% coinsurance; deductible does not apply
	Tier 2/Preferred brand drugs	$25 copay /prescription (retail) $62.50 copay /prescription (mail-order); deductible does not apply	Not covered	
	Tier 3/Non-preferred brand drugs	$40 copay /prescription (retail) $100 copay /prescription (mail-order); deductible does not apply	Not covered	
	Tier 4/Specialty drugs	$40 copay / prescription (specialty pharmacy only);	50% coinsurance; deductible does not apply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		deductible does not apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Preauthorization is recommended
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay/visit; deductible does not apply	$100 copay/visit; deductible does not apply	Emergency room: Copay waived if admitted Urgent Care: Applies to the visit only. If additional services are provided additional out of pockets costs would apply based on services received.
	Emergency medical transportation	$50 copay/trip; deductible does not apply	$50 copay/trip; deductible does not apply	
	Urgent care	$35 copay/urgent care center visit; deductible does not apply	$35 copay plus 20% coinsurance/urgent care center visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	45 day limit at an inpatient rehabilitation facility; Preauthorization is recommended
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit; deductible does not apply No charge/outpatient services; deductible does not apply	$25 copay plus 20% coinsurance/office visit 20% coinsurance/ outpatient services	Preauthorization is recommended for certain services.
	Inpatient services	No charge	20% coinsurance	
If you are pregnant	Office visits	$25 copay/office visit; deductible does not apply	$25 copay plus 20% coinsurance/office visit	Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is recommended.
	Childbirth/delivery professional services	No charge	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	No charge	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	None
	Rehabilitation services	20% coinsurance	20% coinsurance	Includes Physical, Occupational and Speech Therapy. Physical and Occupational. Speech Therapy preauthorization is recommended for all visits. No Charge for services to treat autism spectrum disorder and preauthorization is not required
	Habilitation services	20% coinsurance	20% coinsurance	
	Skilled nursing care	No charge	20% coinsurance	Preauthorization is recommended. Custodial Care is not covered.
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization is recommended for certain services
	Hospice services	No charge	20% coinsurance	Preauthorization is recommended
If your child needs dental or eye care	Children's eye exam	$25 copay/office visit; deductible does not apply	$25 copay plus 20% coinsurance	Limited to one routine eye exam per year.
	Children's glasses	100% of provider charge	100% of provider charge	Limited to $50 per members age 0-18 per occurrence/$50 per member age 19 and over per calendar year for prescription glasses (frames and/or lenses) or contact lenses.
	Children's dental check-up	Not covered	Not covered	None

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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up, child
- Long-term care
- Routine foot care unless to treat a systemic condition
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery • Chiropractic care • Hearing aids	• Infertility treatment • Most coverage provided outside the United States. Contact Customer Service for more information.	• Private-duty nursing • Routine eye care (Adult)

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 us and those agencies is: the plan at 1-800-639-2227 or (401) 459-5000 or TDD 711, state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: contact the plan at 1-800-639-2227 or (401) 459-5000 or TDD 711. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact your state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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:
Para obtener asistencia en Español, llame al 1-800-639-2227.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-639-2227
如果需要中文的帮助，请拨打这个号码1-800-639-2227
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-639-2227.

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

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)

The plan's overall deductible	$500
Specialist copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$670**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$810
Coinsurance	$350
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$240
Copayments	$230
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$520**

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