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 TDD 711 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For In Network providers **$3000** for an individual plan **/ $6000** for a family plan. For Out-of-Network providers **$8000** for an individual plan **/ $16000** for a family plan per calendar year.	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. Doesn't apply to preventive 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 deductible for specific services.
What is the out-of-pocket limit for this plan?	For In Network providers **$6650** for an individual plan **/ $13300** for a family plan. For Out-of-Network providers **$16000** for an individual plan **/ $32000** for a family plan per calendar year.	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, health care this plan doesn't cover and penalties.	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 call 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
		In Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance	50% coinsurance	None
	Specialist visit	30% coinsurance	50% coinsurance	Chiropractic Services are limited to 24 visit(s) per year
	Preventive care/screening/immunization	No Charge; deductible does not apply	50% 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 needed 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)	30% coinsurance	50% coinsurance	Preauthorization is recommended for certain services
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay: In Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition	Tier 1 generally low cost generic drugs	Retail: $10 copay after deductible, Mail-Order: $10 copay after deductible.	Not Covered	Provider means pharmacy for purposes of this section. Mandatory Mail after 3rd fill of a Maintenance Medication at retail. Retail: Up to a 31-day supply. Mail-Order: Up to a 90-day supply. Not all prescription drugs are covered under this plan. You may need to obtain certain drugs, including <u>Specialty drugs</u> from a pharmacy designated by Caremark. Information can be obtained by logging on to your account at www.caremark.com and use the Check Drug Coverage and Cost Tool. Certain preventive medications are covered at no charge. **<u>Specialty Drugs</u>** as approved by CVS Prudent RX program will be covered at $0 copay **if the member is enrolled in the Prudent Rx program.** This is for members who don't have a H.S.A. For members *<u>with</u>* a H.S.A., $0 copay if the drug is on the HDHP Preventive Drug List; for all other drugs, the member will have a $0 copay <u>AFTER</u> the deductible has been satisfied. **If the member is not enrolled in the Prudent Rx program, the member will be subject to 30% coinsurance of the cost of the Specialty drug.**
	Tier 2 generally high cost generic and preferred brand name drugs	Retail: $40 copay after deductible, Mail-Order: $40 copay after deductible.	Not Covered	
	Tier 3 non-preferred brand name drugs	Retail: $75 copay after deductible, Mail-Order: $75 copay after deductible.	Not Covered	
	Tier 4 specialty prescription drugs	CVS Specialty Pharmacy $0 copay or 30% coinsurance after deductible.	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Preauthorization is recommended; Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge.
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	None
	Emergency medical transportation	30% coinsurance	30% coinsurance	
	Urgent care	30% coinsurance	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Preauthorization is recommended; 45 day limit at an inpatient rehabilitation facility; Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge.
	Physician/surgeon fee	30% coinsurance	50% coinsurance	Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance/office visit 30% coinsurance for outpatient services	50% coinsurance/office visit 50% coinsurance for outpatient services	Notification of admission may be required for certain Out-of-Network services.
	Inpatient services	30% coinsurance	50% coinsurance	
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services; In-Network services related to Maternity care covered at No Charge; Preauthorization is recommended.
	Childbirth/delivery professional services	No Charge	50% coinsurance	
	Childbirth/delivery facility services	No Charge	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Preauthorization is recommended
	Rehabilitation services	30% coinsurance	50% coinsurance	Services include Physical, Occupational and Speech Therapy; limited to 30 visits each (combined for in and out of network); services to treat autism spectrum disorder are not subject to visit limits; Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge.
	Habilitation services	30% coinsurance	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	Preauthorization is recommended; Custodial care is not covered
	Durable medical equipment	30% coinsurance	50% coinsurance	Preauthorization is recommended for certain services; Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge.
	Hospice service	30% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	30% coinsurance	50% coinsurance	Limited to one routine eye exam per year.
	Children's glasses	Not Covered	Not Covered	None
	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
- Long-term care
- Routine foot care unless to treat a systemic condition
- Vision care

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 • Most coverage provided outside the United States. Contact Customer Service for more information.	• Private-duty nursing

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

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

Language Access Services:

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** **$3000**
- **Specialist coinsurance** **30%**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

- **The plan's overall deductible** **$3000**
- **Specialist coinsurance** **30%**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,420**

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

- **The plan's overall deductible** **$3000**
- **Specialist coinsurance** **30%**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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