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 **$750** for an individual plan **/ $1500** for a family plan. For Out-of-Network providers **$1000** for an individual plan **/ $2000** 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, services with a fixed dollar copay, prescription drugs, diagnostic testing, imaging services and childbirth/delivery.	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 **$3500** for an individual plan **/ $7000** for a family plan. For Out-of-Network providers **$7000** for an individual plan **/ $14000** 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 copay; deductible does not apply per visit	40% coinsurance	House Calls: 20% coinsurance
	Specialist visit	$40 copay; deductible does not apply per visit	40% coinsurance	Chiropractic Services are limited to 24 visit(s) per year. House Calls: 20% coinsurance
	Preventive care/screening/immunization	No Charge; deductible does not apply	40% 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)	Non-hospital based services: $10 copay, deductible does not apply. Hospital based services: $50 copay, deductible does not apply.	40% coinsurance	Preauthorization is recommended for certain services.
	Imaging (CT/PET scans, MRIs)	Non-hospital based services: $200 copay, deductible does not apply. Hospital based services: $400 copay, deductible does not apply.	40% 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 drugs to treat your illness or condition	Tier 1 generally low-cost generic drugs	Retail: $10 copay, deductible does not apply. Mail-Order: $10 copay, deductible does not apply.	Not Covered	Provider means pharmacy for purposes of this section. Certain preventive medications are covered at no charge. 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 Specialty drugs 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. Specialty Drugs as approved by CVS Prudent RX program will be covered at $0 copay if the member is enrolled in the Prudent Rx program. 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, deductible does not apply. Mail-Order: $40 copay, deductible does not apply.	Not Covered	
	Tier 3 non-preferred brand name drugs	Retail: $75 copay, deductible does not apply. Mail-Order: $75 copay, deductible does not apply.	Not Covered	
	Tier 4 non-preferred brand name drugs	Not applicable	Not applicable	
	Tier 5 specialty prescription drugs	CVS Specialty Pharmacy $0 copay or 30% coinsurance	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)	20% coinsurance	40% coinsurance	Preauthorization is recommended; Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply.
If you need immediate medical attention	Emergency room care	$200 copay; deductible does not apply per visit	$200 copay; deductible does not apply per visit	Emergency room: Copay waived if admitted; Urgent care: Applies to the visit only. If additional services are provided additional out of pocket costs would apply based on services received.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$50 copay; deductible does not apply per urgent care center visit	$50 copay; deductible does not apply per urgent care center visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	45-day limit at an inpatient rehabilitation facility; Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay; deductible does not apply/office visit 20% coinsurance for outpatient services	40% coinsurance/office visit 40% coinsurance for outpatient services	Notification of admission may be required for certain services.
	Inpatient services	20% coinsurance	40% 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 are pregnant	Office visits	$40 copay initial visit only; deductible does not apply	40% coinsurance	Cost sharing does not apply for preventive services; In-Network services related to Maternity care covered at No Charge, deductible does not apply. Preauthorization is recommended.
	Childbirth/delivery professional services	No Charge; deductible does not apply	40% coinsurance	
	Childbirth/delivery facility services	No Charge; deductible does not apply	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	None
	Rehabilitation services	20% coinsurance	40% 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, deductible does not apply.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization is recommended; Custodial care is not covered
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization is recommended for certain services; Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply.
	Hospice service	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	$40 copay; deductible does not apply per visit	40% 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
- Contraceptive services
- 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.

Fer Hilf griege in Deitsch, ruf 1-800-639-2227 uff.

Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-639-2227.

ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-639-2227.

Para un ma ayuda gi finu Chamoru, å'gang 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** **$750**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **20%**
- **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$660**

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

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **20%**
- **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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **20%**
- **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$800
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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