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: **$6,000** individual / **$12,000** family Out-of-Network providers: **$6,000** individual / **$12,000** 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. Preventive care 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?	In-Network: **$6,350** individual / **$12,700** family Out-of-Network: **$6,200** per individual / **$12,400** 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, 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 1-800-639-2227or (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	$25 copay/office visit; deductible does not apply	$25 copay plus 20% coinsurance /office visit	None
	Specialist visit	$40 copay/office visit; deductible does not apply	$40 copay plus 20% coinsurance /office visit	Chiropractic Services are limited to 12 visit(s) per year
	Preventive care/screening/ immunization	No charge; deductible does not apply	$40 copay plus 20% coinsurance	Member liability for 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 More information about **prescription drug coverage** is available at www.BCBSRI.com.	Tier 1/Generic drugs	$7 copay/prescription (retail) $17.50 copay/prescription (mail-order); deductible does not apply	Not covered	No charge for certain preventive 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	$65 copay/prescription (specialty pharmacy); deductible does not apply	$50 copay plus 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)	
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	$150 copay/visit; deductible does not apply	$150 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; deductible does not apply	$50 copay/trip; deductible does not apply	
	Urgent care	$50 copay/urgent care center visit; deductible does not apply	$50 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	$40 copay/office visit No charge /outpatient services; deductible does not apply	$40 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	$40 copay/office visit; deductible does not apply	$40 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	
	Childbirth/delivery facility 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)	
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 Therapy is limited to 30 visits each (combined for in and out of network). Speech Therapy is limited to 30 visits; Preauthorization is recommended for all visits. Services to treat autism spectrum disorder are not subject to visit limits or preauthorization.
	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	$40 copay/office visit; deductible does not apply	$40 copay plus 20% coinsurance /office visit	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 care (Adult)
- Dental check-up, child
- Glasses, 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	$6,000
Specialist copayment	$40
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	$6,000
Copayments	$110
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,170**

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

The plan's overall deductible	$6,000
Specialist copayment	$40
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	$1,730
Copayments	$1,070
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,860**

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

The plan's overall deductible	$6,000
Specialist copayment	$40
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	$850
Copayments	$270
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,120**

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