**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 **$6000** for an individual plan **/ $12000** 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.<br>Doesn't apply to preventive services, services with a fixed dollar copay and prescription 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. 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 **$12000** for an individual plan **/ $24000** 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 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?** | Yes | This plan will pay some of all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

- 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 | $50 copay; deductible does not apply per visit | Not Covered | None |
| | Specialist visit | $55 copay; deductible does not apply per visit | Not Covered | Chiropractic Services: $45 copay; deductible does not apply. Limited to 20 visit(s) per year. Acupuncture: $45 copay; deductible does not apply. Limited to 12 visit(s) per year. |
| | Preventive care/screening/immunization | No Charge; deductible does not apply | Not Covered | 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) | $100 copay per procedure for x-ray<br>$50 copay per procedure for blood work | Not Covered | Preauthorization is recommended for certain services |
| | Imaging (CT/PET scans, MRIs) | No Charge | 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 need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.BCBSRI.com. | Tier 1 generally low cost generic drugs | $7 copay; deductible does not apply per prescription (retail)<br>$17.50 copay; deductible does not apply per prescription (mail-order) | Not Covered | No charge for certain preventive drugs; Preauthorization is required for certain drugs; $150 maximum charge per prescription at an In-Network Specialty pharmacy; Infertility drugs: 20% coinsurance up to a $150 maximum deductible does not apply. |
| | Tier 2 generally includes other certain low cost preferred generic prescription drugs | $25 copay; deductible does not apply per prescription (retail)<br>$62.50 copay; deductible does not apply per prescription (mail-order) | Not Covered | |
| | Tier 3 generally includes high cost non-preferred generic prescription drugs and preferred brand name prescription drugs | $100 copay; deductible does not apply per prescription (retail)<br>$250 copay; deductible does not apply per prescription (mail-order) | Not Covered | |
| | Tier 4 generally includes non-preferred brand name drugs | $125 copay; deductible does not apply per prescription (Specialty pharmacy)<br>$375 copay; deductible does not apply per prescription (mail-order) | Not Covered | |
| | Tier 5 specialty prescription drugs | $150 copay; deductible does not apply per prescription (Specialty pharmacy)<br>50% coinsurance; deductible does not apply (retail) | 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) | No Charge | Not Covered | 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 | No Charge | Not Covered | 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 | $400 copay per visit | $400 copay 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 | $50 copay; deductible does not apply per trip | $50 copay; deductible does not apply per trip | |
| | Urgent care | $150 copay; deductible does not apply per urgent care center visit | $150 copay; deductible does not apply per urgent care center visit | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No Charge | Not Covered | 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, deductible does not apply. |
| | Physician/surgeon fee | No Charge | Not Covered | 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 | $50 copay; deductible does not apply/office visit No Charge for outpatient services | Not Covered | Notification of admission may be required for certain services |
| | Inpatient services | No Charge | 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 are pregnant** | Office visits | $55 copay; deductible does not apply per visit | Not Covered | Cost sharing does not apply for preventive services; Depending on the type of services, a copayment, coinsurance or deductible 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 | Not Covered | |
| | Childbirth/delivery facility services | No Charge | Not Covered | |
| **If you need help recovering or have other special health needs** | Home health care | No Charge | Not Covered | None |
| | Rehabilitation services | 20% coinsurance | Not Covered | Services include Physical, Occupational and Speech Therapy; Preauthorization is recommended for certain services; No Charge for services to treat autism spectrum disorder; Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply; |
| | Habilitation services | 20% coinsurance | Not Covered | |
| | Skilled nursing care | No Charge | Not Covered | Preauthorization is recommended; Custodial care is not covered |
| | Durable medical equipment | 20% coinsurance | Not Covered | 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 | No Charge | Not Covered | None |
| **If your child needs dental or eye care** | Children's eye exam | $55 copay; deductible does not apply per visit | Not Covered | Limited to one routine eye exam per year. |
| | Children's glasses | No Charge; deductible does not apply | Not Covered | Limited to one pair of eyeglasses per year |
| | 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.)**

- 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.)**

- Acupuncture
- 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**.
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.

*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** **$6000**
- **Specialist copayment** **$55**
- **Hospital (facility) coinsurance** **No Charge**
- **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 | $6,000 |
| Copayments | $70 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$6,130** |

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

- **The plan's overall deductible** **$6000**
- **Specialist copayment** **$55**
- **Hospital (facility) coinsurance** **No Charge**
- **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 | $600 |
| Copayments | $600 |
| 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** **$6000**
- **Specialist copayment** **$55**
- **Hospital (facility) coinsurance** **No Charge**
- **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 | $1,500 |
| Copayments | $200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,700** |

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