



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 \$2000 for an individual plan / \$4000 for a family plan. For Out-of-Network providers \$4000 for an individual plan / \$8000 for a family plan. | Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your deductible? | Yes. Doesn't apply to preventive services, services with a fixed dollar copay and prescription drugs. | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . 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 \$6000 for an individual plan / \$12000 for a family plan. For Out-of-Network providers \$12000 for an individual plan / \$24000 for a family plan. | The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limits</u> 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 <u>out-of-pocket limit</u> . |
| 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 <u>network providers</u> . | 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 <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a referral to see a specialist? | Yes | This <u>plan</u> will pay some of all of the costs to see a <u>specialist</u> for covered services but only if you have a referral before you see the <u>specialist</u> . |



- 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 | \$25 copay; deductible does not apply per visit | 40% coinsurance | None |
| | Specialist visit | \$40 copay; deductible does not apply per visit | 40% coinsurance | Chiropractic Services are limited to 20 visit(s) per year |
| | Preventive care/ screening/immunization | No Charge; deductible does not apply | 40% coinsurance | 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) | \$75 copay; deductible does not apply for x-ray \$25 copay; deductible does not apply for blood work | 40% coinsurance | Preauthorization is recommended for certain services |
| | Imaging (CT/PET scans, MRIs) | No Charge | 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 More information about <u>prescription drug coverage</u> is available at www.BCBSRI.com . | Tier 1 generally low cost generic drugs | \$10 copay; deductible does not apply per prescription (retail) \$25 copay; deductible does not apply per 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 generally high cost generic and preferred brand name drugs | \$35 copay; deductible does not apply per prescription (retail) \$87.50 copay; deductible does not apply per prescription (mail-order) | Not Covered | |
| | Tier 3 non-preferred brand name drugs | \$70 copay; deductible does not apply per prescription (retail) \$210 copay; deductible does not apply per prescription (mail-order) | Not Covered | |
| | Tier 4 specialty prescription drugs | \$150 copay; deductible does not apply per prescription (Specialty pharmacy) 50% coinsurance; deductible does not apply (retail) | Not Covered | |
| | Tier 5 specialty prescription drugs | \$300 copay; deductible does not apply per prescription (Specialty pharmacy) 50% coinsurance; deductible does not apply (retail) | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | Preauthorization is recommended |

| 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) | |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| 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 pockets 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 | \$100 copay; deductible does not apply per urgent care center visit | \$100 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; Preauthorization is recommended |
| | Physician/surgeon fee | 20% coinsurance | 40% coinsurance | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$40 copay; deductible does not apply/office visit 20% coinsurance for outpatient services | 40% coinsurance/office visit 40% coinsurance for outpatient services | Preauthorization is recommended for certain services |
| | Inpatient services | 20% coinsurance | 40% coinsurance | |
| If you are pregnant | Office visits | \$40 copay; deductible does not apply per visit | 40% 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 | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 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 | Includes Physical, Occupational and Speech Therapy. Speech Therapy preauthorization is recommended for all visits; Services to treat autism spectrum disorder are not subject to preauthorization. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Custodial care is not covered; Preauthorization is recommended |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Preauthorization is recommended for certain services. |
| | Hospice service | 20% coinsurance | 40% coinsurance | Preauthorization is recommended |

| 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 your child needs dental or eye care | Children's eye exam | No Charge; deductible does not apply | 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.) | | |
|--|--|--|
| <ul style="list-style-type: none"> Acupuncture Cosmetic surgery Dental care (Adult) | <ul style="list-style-type: none"> Dental check-up, child Glasses, child Long-term care | <ul style="list-style-type: none"> 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.) | | |
|--|---|--|
| <ul style="list-style-type: none"> Bariatric Surgery Chiropractic care Hearing aids | <ul style="list-style-type: none"> Infertility treatment Most coverage provided outside the United States. Contact Customer Service for more information. Private-duty nursing | <ul style="list-style-type: none"> 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 HealthInquiry@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 HealthInquiry@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, kwijigo 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 **\$2000**
- 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 | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2,000 |
| Copayments | \$300 |
| Coinsurance | \$1,900 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$4,260 |

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

- The plan's overall deductible **\$2000**
- 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 | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2,000 |
| Copayments | \$600 |
| Coinsurance | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$30 |
| The total Joe would pay is | \$2,830 |

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

- The plan's overall deductible **\$2000**
- 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 | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,900 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,900 |

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