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?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
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 **$750** for an individual plan / **$1500** 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	$15 copay per visit	Not Covered	$5 copay per visit if PCP is a part of a Patient Center Medical Home (PCMH)
	Specialist visit	$20 copay per visit	Not Covered	$45 copay for Chiropractic Services limited to 12 visits per year
	Preventive care/ screening/immunization	No Charge	Not Covered	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)	10% coinsurance	Not Covered	Preauthorization is recommended for certain services.
	Imaging (CT/PET scans, MRIs)	10% 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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.BCBSRI.com.	Tier 1 generally low cost generic drugs	$5 copay per prescription (retail) $12.50 copay per prescription (mail-order)	Not Covered	No charge for certain preventive drugs; Preauthorization is required for certain drugs; Infertility drugs: 20% coinsurance.
	Tier 2 generally includes other certain low cost preferred generic prescription drugs	$15 copay per prescription (retail) $37.50 copay per prescription (mail-order)	Not Covered	
	Tier 3 generally includes high cost non-preferred generic prescription drugs and preferred brand name prescription drugs	$30 copay per prescription (retail) $75 copay per prescription (mail-order)	Not Covered	
	Tier 4 generally includes non-preferred brand name drugs	$50 copay per prescription (retail) $150 copay per prescription (mail-order)	Not Covered	
	Tier 5 specialty prescription drugs	$100 copay per prescription (Specialty pharmacy) 50% coinsurance (retail)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not Covered	Preauthorization is recommended
	Physician/surgeon fees	10% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	Air/Water Ambulance: 10% Coinsurance; $3,000 maximum per occurrence. 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 per trip	$50 copay per trip	
	Urgent care	$75 copay per urgent care center visit	$75 copay per urgent care center visit	

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 a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not Covered	45 day limit at an inpatient rehabilitation facility; Preauthorization is recommended
	Physician/surgeon fee	10% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit 10% coinsurance for outpatient services	Not Covered	Preauthorization is recommended for certain services
	Inpatient services	10% coinsurance	Not Covered	
If you are pregnant	Office visits	$20 copay per visit	Not Covered	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	10% coinsurance	Not Covered	
	Childbirth/delivery facility services	10% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not Covered	None
	Rehabilitation services	10% coinsurance	Not Covered	Includes Physical, Occupational and Speech Therapy.
	Habilitation services	10% coinsurance	Not Covered	
	Skilled nursing care	10% coinsurance	Not Covered	None
	Durable medical equipment	10% coinsurance	Not Covered	Preauthorization is recommended for certain services.
	Hospice service	10% coinsurance	Not Covered	Preauthorization is recommended
If your child needs dental or eye care	Children's eye exam	$30 copay; deductible does not apply per visit	Not Covered	Limited to one routine eye exam per year; $20 copay for medically necessary exams
	Children's glasses	10% Coinsurance	Not Covered	Limited to one pair of eyeglasses per year
	Children's dental check-up	No Charge	Not Covered	Limit to 2 visit(s) per year

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) • 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.)		
• Abortion • 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.

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	**$**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$0
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$860**

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

The plan's overall deductible	**$**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$0
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$530**

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

The plan's overall deductible	**$**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$0
Copayments	$90
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$190**

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