



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](http://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:                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | For In Network providers <b>\$2250</b> for an individual plan / <b>\$4500</b> 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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.                                                                                                                                                                                                                      |
| <b>Are there services covered before you meet your deductible?</b> | Yes.<br>Doesn't apply to preventive services.                                                                                                 | 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| <b>Are there other deductibles for specific services?</b>          | No                                                                                                                                            | You don't have to meet deductible for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>What is the out-of-pocket limit for this plan?</b>              | For In Network providers <b>\$3650</b> for an individual plan / <b>\$7300</b> 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.                                                                                                                                                                                                                                    |
| <b>What is not included in the out-of-pocket limit?</b>            | 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> .                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="http://www.BCBSRI.com">www.BCBSRI.com</a> 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.     |
| <b>Do you need a referral to see a specialist?</b>                 | No                                                                                                                                            | You can see the <u>specialist</u> 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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                      |
| <b>If you visit a health care <u>provider's</u> office or clinic</b> | Primary care visit to treat an injury or illness | 20% coinsurance                                 | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                 |
|                                                                      | Specialist visit                                 | 20% coinsurance                                 | Not Covered                                        | Chiropractic Services are limited to 12 visit(s) per year                                                                                                                                                                                                                                                            |
|                                                                      | Preventive care/<br>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 you need are preventive. Then check what your plan will pay for. For additional details, please see your plan documents or visit <a href="http://www.BCBSRI.com/providers/policies">www.BCBSRI.com/providers/policies</a> |
| <b>If you have a test</b>                                            | Diagnostic test (x-ray, blood work)              | 20% coinsurance                                 | Not Covered                                        | Preauthorization is recommended for certain services                                                                                                                                                                                                                                                                 |
|                                                                      | Imaging (CT/PET scans, MRIs)                     | 20% 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) |                                                                                                                            |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.BCBSRI.com">www.BCBSRI.com</a> . | Tier 1 generally low cost generic drugs                                                                                  | No Charge (retail & 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)<br>\$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 | \$50 copay per prescription (retail)<br>\$125 copay per prescription (mail-order)   | Not Covered                                     |                                                                                                                            |
|                                                                                                                                                                                                         | Tier 4 generally includes non-preferred brand name drugs                                                                 | \$75 copay per prescription (retail)<br>\$225 copay per prescription (mail-order)   | Not Covered                                     |                                                                                                                            |
|                                                                                                                                                                                                         | Tier 5 specialty prescription drugs                                                                                      | \$100 copay per prescription (Specialty pharmacy)<br>50% coinsurance (retail)       | Not Covered                                     |                                                                                                                            |
| <b>If you have outpatient surgery</b>                                                                                                                                                                   | Facility fee (e.g., ambulatory surgery center)                                                                           | 20% coinsurance                                                                     | Not Covered                                     | Preauthorization is recommended                                                                                            |
|                                                                                                                                                                                                         | Physician/surgeon fees                                                                                                   | 20% coinsurance                                                                     | Not Covered                                     | None                                                                                                                       |
| <b>If you need immediate medical attention</b>                                                                                                                                                          | Emergency room care                                                                                                      | 20% coinsurance                                                                     | 20% coinsurance                                 | Air/Water Ambulance: 20% Coinsurance; \$3000 maximum per occurrence.                                                       |
|                                                                                                                                                                                                         | Emergency medical transportation                                                                                         | \$50 copay per trip                                                                 | \$50 copay per trip                             |                                                                                                                            |
|                                                                                                                                                                                                         | Urgent care                                                                                                              | 20% coinsurance                                                                     | 20% coinsurance                                 |                                                                                                                            |
| <b>If you have a hospital stay</b>                                                                                                                                                                      | Facility fee (e.g., hospital room)                                                                                       | 20% coinsurance                                                                     | Not Covered                                     | 45 day limit at an inpatient rehabilitation facility; Preauthorization is recommended                                      |
|                                                                                                                                                                                                         | Physician/surgeon fee                                                                                                    | 20% coinsurance                                                                     | Not Covered                                     | None                                                                                                                       |

| 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 mental health, behavioral health, or substance abuse services | Outpatient services                       | 20% coinsurance/<br>office visit<br>20% coinsurance for<br>outpatient services | Not Covered                                     | Preauthorization is recommended for certain services                                                                                                                                       |
|                                                                           | Inpatient services                        | 20% coinsurance                                                                | Not Covered                                     |                                                                                                                                                                                            |
| If you are pregnant                                                       | Office visits                             | 20% coinsurance                                                                | 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 | 20% coinsurance                                                                | Not Covered                                     |                                                                                                                                                                                            |
|                                                                           | Childbirth/delivery facility services     | 20% coinsurance                                                                | Not Covered                                     |                                                                                                                                                                                            |
| If you need help recovering or have other special health needs            | Home health care                          | 20% coinsurance                                                                | Not Covered                                     | None                                                                                                                                                                                       |
|                                                                           | Rehabilitation services                   | 20% coinsurance                                                                | Not Covered                                     | Includes Physical, Occupational and Speech Therapy.                                                                                                                                        |
|                                                                           | Habilitation services                     | 20% coinsurance                                                                | Not Covered                                     |                                                                                                                                                                                            |
|                                                                           | Skilled nursing care                      | 20% coinsurance                                                                | Not Covered                                     | Custodial care is not covered; Preauthorization is recommended                                                                                                                             |
|                                                                           | Durable medical equipment                 | 20% coinsurance                                                                | Not Covered                                     | Preauthorization is recommended for certain services.                                                                                                                                      |
|                                                                           | Hospice service                           | 20% coinsurance                                                                | Not Covered                                     | Preauthorization is recommended                                                                                                                                                            |
| If your child needs dental or eye care                                    | Children's eye exam                       | 20% coinsurance                                                                | Not Covered                                     | Limited to one routine eye exam per year.                                                                                                                                                  |
|                                                                           | Children's glasses                        | 20% Coinsurance                                                                | Not Covered                                     | Limited to one pair of eyeglasses per year                                                                                                                                                 |
|                                                                           | Children's dental check-up                | No Charge                                                                      | Not Covered                                     | Limited to 2 visit(s) per year                                                                                                                                                             |

### Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other excluded services.) |                       |                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|----------------------------------------------------------|
| • Abortion (except in cases of rape, incest, or when the life of the mother is endangered)                                                                     | • Cosmetic surgery    | • Routine foot care unless to treat a systemic condition |
| • Acupuncture                                                                                                                                                  | • Dental care (Adult) | • Weight loss programs                                   |
|                                                                                                                                                                | • Long-term 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
- 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](mailto:HealthInsInquiry@ohic.ri.gov), Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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](http://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](http://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](mailto: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 \$2250
- Specialist copayment \$0
- 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,250        |
| Copayments                        | \$0            |
| Coinsurance                       | \$1,400        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,710</b> |

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

- The plan's overall deductible \$2250
- Specialist copayment \$0
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,250        |
| Copayments                        | \$0            |
| Coinsurance                       | \$200          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$30           |
| <b>The total Joe would pay is</b> | <b>\$2,480</b> |

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

- The plan's overall deductible \$2250
- Specialist copayment \$0
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

**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            |
| <b>The total Mia would pay is</b> | <b>\$1,900</b> |

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