



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 1-866-987-3706 or (401) 429-2102 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 1-866-987-3706 or TDD 711 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	Combined deductible for Preferred Network and In-Network providers \$2,000 for an individual plan / \$4,000 for a family plan. For Out-of-Network providers \$4,000 for an individual plan / \$8,000 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.
Are there services covered before you meet your <u>deductible</u>?	Yes. 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet deductible for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Combined out-of-pocket limit for Preferred Network and In-Network providers \$4,000 for an individual plan / \$8,000 for a family plan. For Out-of-Network providers \$11,000 for an individual plan / \$22,000 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, the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u>?	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 <u>network provider</u>?	Yes. See www.BCBSRI.com or call 1-866-987-3706 or (401) 429-2102 for a list of <u>network providers</u> .	You pay the least if you use a provider in Preferred Network. You pay more if you use a provider in In-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 <u>referral</u> to see a <u>specialist</u>?	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
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay the more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	20% coinsurance	50% coinsurance	None
	Specialist visit	10% coinsurance	20% coinsurance	50% coinsurance	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	No Charge; deductible does not apply	50% coinsurance	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)	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is recommended for certain services
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	50% coinsurance	

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If you need drugs to treat your illness or condition	Tier 1 generally low cost generic drugs	Brown University Health Pharmacy: \$5 copay Retail Pharmacy: \$10 copay		Not Covered	A 90-day supply of maintenance medication may be available at a Brown University Health Pharmacy for a cost that is twice the 30- day supply. A 90-day supply of maintenance medication may be available through ESI's mail order pharmacy for a cost that is twice the retail pharmacy 30- day supply. Certain utilization management programs apply that may require prior authorization, step therapy or impose quantity limits on drugs dispensed.
	Tier 2 generally high cost generic and preferred brand name drugs	Brown University Health Pharmacy: \$15 copay Retail Pharmacy: \$60 copay			
	Tier 3 non-preferred brand name drugs	Brown University Health Pharmacy: \$25 copay Retail Pharmacy: 40% coinsurance (minimum/maximum copay: \$80/\$120)			
	Tier 4 specialty prescription drugs	Paid at tier 1, 2, or 3 depending on drug			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	50% coinsurance	Some surgeries require pre-authorization.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	50% coinsurance	Some surgeries require pre-authorization.
If you need immediate medical attention	Emergency room care	\$200 copay per visit			Emergency room: Copay waived if admitted; Emergency medical transportation may require pre-authorization.
	Emergency medical transportation	10% coinsurance			
	Urgent care	10% coinsurance	20% coinsurance	50% coinsurance	Urgent care: Applies to the visit only. If additional services are provided, additional out of pocket costs would apply based on services received..

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If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	50% coinsurance	Inpatient rehabilitation facility: In-Network 10% Coinsurance; 100-day limit Pre-authorization may be required.
	Physician/surgeon fee	10% coinsurance	20% coinsurance	50% coinsurance	Pre-authorization may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance/office visit 10% coinsurance for outpatient services		50% coinsurance/office visit 50% coinsurance for outpatient services	Notification of admission may be required for certain services.
	Inpatient services	10% coinsurance		50% coinsurance	
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	50% coinsurance	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	10% coinsurance	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	50% coinsurance	

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		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay the more)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	50% coinsurance	None
	Rehabilitation services	10% coinsurance	10% coinsurance	50% coinsurance	Services include Physical, Occupational and Speech Therapy;
	Habilitation services	10% coinsurance	10% coinsurance	50% coinsurance	
	Skilled nursing care	10% coinsurance	20% coinsurance	50% coinsurance	Custodial care is not covered; Pre-authorization may be required; limited to 100 days per calendar year
	Durable medical equipment	10% coinsurance	10% coinsurance	50% coinsurance	All In-Network services apply the Preferred Network benefits. Pre-authorization may be required.
	Hospice service	10% coinsurance	20% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	10% coinsurance	20% coinsurance	50% coinsurance	Limited to one routine eye exam per year.
	Children's glasses	Not Covered	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None

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 <u>excluded services</u> .)		
• Cosmetic surgery	• Glasses, child	• Private-duty nursing
• Dental care (Adult)	• Long-term care	• Routine foot care unless to treat a systemic condition
• Dental check-up, child		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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|---------------------|--|----------------------------|
| • Acupuncture | • Hearing aids | • Routine eye care (Adult) |
| • Bariatric Surgery | • Infertility treatment | • Weight loss programs |
| • Chiropractic care | • Most coverage provided outside the United States. Contact Customer Service for more information. | |

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 1-866-987-3706 or (401) 429-2102 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 1-866-987-3706 or (401) 429-2102 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.

Language Access Services:

Para obtener asistencia en Español, llame al 1-866-987-3706.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-987-3706.

如果需要中文的帮助, 请拨打这个号码 1-866-987-3706.

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-987-3706.

Fer Hilf griege in Deutsch, ruf 1-866-987-3706 uff.

Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-987-3706.

ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-987-3706.

Para un ma ayuda gi finu Chamoru, a'gang 1-866-987-3706.

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 <u>deductible</u>	\$2000
■ <u>Specialist copayment</u>	\$0
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$10
Coinsurance	\$1,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,170

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$2000
■ <u>Specialist copayment</u>	\$0
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$100
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,220

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$2000
■ <u>Specialist copayment</u>	\$0
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$80
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,080

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