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 deductible?	For Preferred Network **$0** for an individual plan **/ $0** for a family plan. For In-Network **$0** for an individual plan **/ $0** for a family plan. For Out-of-Network providers **$2,000** for an individual plan **/ $4,000** 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.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Combined medical and pharmacy out-of-pocket limit for Preferred Network and In-Network providers **$2,500** for an individual plan **/ $5,000** for a family plan. For Out-of-Network providers **$3,000** for an individual plan **/ $6,000** for a family plan.	The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit 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 1-866-987-3706 or (401) 429-2102 for a list of network providers.	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 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?	No	You can see the specialist 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 provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	$20 copay per visit	20% coinsurance	None
	Specialist visit	$20 copay per visit	$20 copay per visit	20% coinsurance	$30 copay for Acupuncture Services
	Preventive care/screening/immunization	No Charge	No Charge	20% 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)	No Charge	General imaging: $50 copay Lab tests: $25 copay	20% coinsurance	Pre-authorization may be required for certain services.
	Imaging (CT/PET scans, MRIs)	No Charge	$50 copay	20% coinsurance	

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 need drugs to treat your illness or condition **(cost is shown for up to a 30-day supply)**	Tier 1 generally low cost generic drugs	Lifespan Pharmacy: $5 copay Retail Pharmacy: $10 copay		Reimbursable at in-network level	A 90-day supply of maintenance medication may be available through ESI's mail order pharmacy for a copay 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	Lifespan Pharmacy: $15 copay Retail Pharmacy: $30 copay			
	Tier 3 non-preferred brand name drugs	Lifespan Pharmacy: $25 copay Retail Pharmacy: $50 copay			
	Tier 4 specialty prescription drugs	Lifespan Pharmacy: $35 copay ESI Mail Order (through Accredo): $100 copay			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	$300 copay	20% coinsurance	Some surgeries require pre-authorization.
	Physician/surgeon fees	No Charge	No Charge	20% coinsurance	Some surgeries require pre-authorization.
If you need immediate medical attention	Emergency room care	$100 copay per visit; waived if admitted to hospital			Emergency medical transportation may require pre-authorization. Urgent care copay applies to the visit only; Additional out of pocket costs may apply based on services received.
	Emergency medical transportation	$50 copay per trip			
	Urgent care	$30 copay per visit	$30 copay per visit	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	$500 copay per admission	20% coinsurance	Pre-authorization may be required; 100 day limit at an inpatient rehabilitation facility.
	Physician/surgeon fee	No Charge	No Charge	20% coinsurance	Pre-authorization may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay per visit		20% coinsurance	Notification of admission may be required for certain services.
	Inpatient services	No Charge	No Charge	20% coinsurance	

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 are pregnant	Office visits	$20 copay per visit	$20 copay per visit	20% 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	No Charge	No Charge	20% coinsurance	
	Childbirth/delivery facility services	No Charge	No Charge	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	20% coinsurance	Pre-authorization may be required.
	Rehabilitation services	No Charge	$20 copay	20% coinsurance	Physical and occupational therapy: $320 combined annual copayment cap; Speech therapy: $320 annual copayment cap (not combined with physical and occupational therapy).
	Habilitation services	No Charge	$20 copay	20% coinsurance	
	Skilled nursing care	No Charge	No Charge	20% coinsurance	Pre-authorization may be required; limited to 100 days per calendar year (combined for in and out of network); custodial care is not covered
	Durable medical equipment	No Charge	$40 copay	20% coinsurance	Pre-authorization may be required.
	Hospice service	No Charge	No Charge	20% coinsurance	None
If your child needs dental or eye care	Children's eye exam	$20 copay per visit		20% 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 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
- Glasses, child
- Long-term care (custodial)
- Private-duty nursing
- Routine foot care unless to treat a systemic condition

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.
- Routine eye care (Adult)
- Weight loss programs

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, kwiijigo holne' 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 deductible	**$0**
Specialist copayment	**$20**
Hospital (facility) copayment	**No Charge**
Other coinsurance	**No Charge**

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	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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

The plan's overall deductible	**$0**
Specialist copayment	**$20**
Hospital (facility) copayment	**No Charge**
Other coinsurance	**No Charge**

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	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$620**

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

The plan's overall deductible	**$0**
Specialist copayment	**$20**
Hospital (facility) copayment	**No Charge**
Other coinsurance	**No Charge**

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	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$30**

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