




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 (401) 459-5000 or TDD 711 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	Out-of-Network: <b>\$100</b> individual / <b>\$100</b> per member (maximum of 3 members) for a family plan	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Emergency room services and emergency medical transportation	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Out-of-Network: <b>\$1000</b> individual / <b>\$1000</b> per member (maximum of 3 members) for a family plan	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Premiums, balance-billed charges, health care this plan doesn't cover, fixed dollar copays, deductible, infertility services, rehabilitative and habilitative services and durable medical equipment.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.BCBSRI.com">www.BCBSRI.com</a> or by calling 1-800-639-2227 or (401) 459-5000 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a> /office visit	\$15 <a href="#">copay</a> /office visit plus 20% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> /office visit	\$20 <a href="#">copay</a> /office visit plus 20% <a href="#">coinsurance</a>	Chiropractic Services are limited to 12 visit(s) per year.
	<a href="#">Preventive care/screening/immunization</a>	\$15 <a href="#">copay</a>	\$20 <a href="#">copay</a> /office visit plus 20% <a href="#">coinsurance</a>	\$20 copay for Well-Woman Annual/Preventive office visit. Member liability for In Network and Out-of-Network is based on services received; 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>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	20% <a href="#">coinsurance</a>	Preauthorization is recommended for certain services.
	Imaging (CT/PET scans, MRIs)	No charge	20% <a href="#">coinsurance</a>	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.BCBSRI.com">www.BCBSRI.com</a> .	Tier 1/Generic drugs	Retail: \$5 Mail-Order: \$10	Retail: \$5 Mail-Order: \$10	Contact your Plan Administrator for additional information
	Tier 2/Preferred brand drugs	Retail: \$15 Mail-Order: \$30	Retail: \$15 Mail-Order: \$30	
	Tier 3/Non-preferred brand drugs	Retail: \$30 Mail-Order: \$60	Retail: \$30 Mail-Order: \$60	
	Tier 4/Specialty drugs	N/A	N/A	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	20% <a href="#">coinsurance</a>	Preauthorization is recommended.
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	\$100 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	Emergency room: Copay waived if admitted Ambulance:\$3000 maximum per occurrence for Air/Water Ambulance Urgent Care: Visit only; additional services received are subject to additional out-of-pocket costs.
	<a href="#">Emergency medical transportation</a>	\$50 <a href="#">copay</a> /trip; <a href="#">deductible</a> does not apply	\$50 <a href="#">copay</a> /trip; <a href="#">deductible</a> does not apply	
	<a href="#">Urgent care</a>	\$15 <a href="#">copay</a> /urgent care center visit	\$15 <a href="#">copay</a> /urgent care center visit; plus 20% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% <a href="#">coinsurance</a>	45 day limit at an inpatient rehabilitation facility; Preauthorization is recommended
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <a href="#">copay</a> /office visit No charge <a href="#">/outpatient services</a>	\$20 <a href="#">copay</a> /office visit plus 20% <a href="#">coinsurance</a> 20% <a href="#">coinsurance</a> / <a href="#">outpatient services</a>	Preauthorization is recommended for certain services.
	Inpatient services	No charge	20% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	\$20 <a href="#">copay</a> /office visit	\$20 <a href="#">copay</a> /office visit plus 20% <a href="#">coinsurance</a>	Depending on the type of services, <a href="#">coinsurance</a> 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	20% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	No charge	20% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	20% <a href="#">coinsurance</a>	None
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Includes Physical, Occupational and Speech Therapy. Physical and Occupational. Speech Therapy preauthorization is recommended for all visits. No Charge for services to treat autism spectrum disorder and preauthorization is not required
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	No charge	20% <a href="#">coinsurance</a>	Preauthorization is recommended. Custodial Care is not covered.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Preauthorization is recommended for certain services.
	<a href="#">Hospice services</a>	No charge	20% <a href="#">coinsurance</a>	Preauthorization is recommended.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	\$20 <a href="#">copay</a> /office visit	\$20 <a href="#">copay</a> /office visit plus 20% <a href="#">coinsurance</a>	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](#).)

- |                       |                          |  |
|-----------------------|--------------------------|--|
| • Acupuncture         | • Dental check-up, child | • Prescription Drugs                                     |
| • Cosmetic surgery    | • Glasses, child         | • Routine foot care unless to treat a systemic condition |
| • Dental care (Adult) | • Long-term care         | • Weight loss programs                                   |

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

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

**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](#).

**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](#) \$0
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 0%
- 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>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$130
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Peg would pay is</b>	<b>\$230</b>

**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) [coinsurance](#) 0%
- 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>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$220
Coinsurance	\$350
<i>What isn't covered</i>	
Limits or exclusions	\$4,310
<b>The total Joe would pay is</b>	<b>\$4,880</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 0%
- 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>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$380
Coinsurance	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$00
<b>The total Mia would pay is</b>	<b>\$430</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.