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?	Combined deductible for In Network and Out-of-Network providers **$50** for an individual plan **/ $50** per member (maximum of 2 members) 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. Doesn't apply to services with a fixed dollar copay, diagnostic testing, imaging services, infertility services, inpatient services and some outpatient 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.
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?	Combined out-of-pocket limit for In Network and Out-of-Network providers **$500 / $500** per member (maximum of 2 members) 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, health care this plan doesn't cover, deductible and infertility services.	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?	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
		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	20% coinsurance	20% coinsurance	None
	Specialist visit	20% coinsurance	20% coinsurance	None
	Preventive care/screening/immunization	20% coinsurance	20% coinsurance	Member liability for In-Network and Out-of-Network is based on services received; 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; deductible does not apply	No Charge; deductible does not apply	Preauthorization is recommended for certain services
	Imaging (CT/PET scans, MRIs)	No Charge; deductible does not apply	No Charge; deductible does not apply	
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	Retail: $2 Mail-Order: $6	Retail: $2 Mail-Order: $6	Contact your Plan Administrator for additional information
	Tier 2 generally high cost generic and preferred brand name drugs	Retail: $2 Mail-Order: $6	Retail: $2 Mail-Order: $6	
	Tier 3 non-preferred brand name drugs	N/A	N/A	
	Tier 4 specialty prescription drugs	N/A	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge; deductible does not apply	No Charge; deductible does not apply	Preauthorization is recommended
	Physician/surgeon fees	No Charge; deductible does not apply	No Charge; deductible does not apply	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 immediate medical attention	Emergency room care	No Charge; deductible does not apply	No Charge; deductible does not apply	Air/Water Ambulance: $3000 maximum per occurrence
	Emergency medical transportation	$50 copay; deductible does not apply per trip	$50 copay; deductible does not apply per trip	
	Urgent care	20% coinsurance	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge; deductible does not apply	No Charge; deductible does not apply	45 day limit at an inpatient rehabilitation facility; Preauthorization is recommended
	Physician/surgeon fee	No Charge; deductible does not apply	No Charge; deductible does not apply	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance/office visit No Charge; deductible does not apply for outpatient services	20% coinsurance/office visit No Charge; deductible does not apply for outpatient services	Preauthorization is recommended for certain services
	Inpatient services	No Charge; deductible does not apply	No Charge; deductible does not apply	
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	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	No Charge; deductible does not apply	No Charge; deductible does not apply	
	Childbirth/delivery facility services	No Charge; deductible does not apply	No Charge; deductible does not apply	
If you need help recovering or have other special health needs	Home health care	No Charge; deductible does not apply	No Charge; deductible does not apply	Private duty nursing: 20% coinsurance
	Rehabilitation services	20% coinsurance	20% coinsurance	Includes Physical, Occupational and Speech Therapy. No Charge; deductible does not apply for services to treat autism spectrum disorder.
	Habilitation services	20% coinsurance	20% coinsurance	
	Skilled nursing care	No Charge; deductible does not apply	No Charge; deductible does not apply	Custodial care is not covered; Preauthorization is recommended
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization is recommended for certain services.
	Hospice service	No Charge; deductible does not apply	No Charge; deductible does not apply	Preauthorization is recommended

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 your child needs dental or eye care	Children's eye exam	$20 copay; deductible does not apply per visit	$20 copay; deductible does not apply per visit	Limited to one routine eye exam per year. Medically necessary exams are covered at 20% coinsurance
	Children's glasses	100% of provider charge; deductible does not apply	100% of provider charge; deductible does not apply	Limited to 1 pair of lenses, or contact lenses, per year up to $18 per pair; Limited to 1 pair of eyeglass frames every other year (24 month period) at $12 per eyeglass frames.
	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
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up, child
- Long-term care
- Prescription Drugs
- 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.)

- 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? No .
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? No.
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, kwiijigo 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** **$50**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **No Charge**
- **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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$50
Copayments	$0
Coinsurance	$10
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$160**

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

- **The plan's overall deductible** **$50**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **No Charge**
- **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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$4,800
The total Joe would pay is	**$5,250**

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

- **The plan's overall deductible** **$50**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **No Charge**
- **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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$50
Copayments	$50
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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