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 1-401-459-5000 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?	In-Network: **$0** Out-of-Network: **$200**/individual; **$600**/family	In-network: See the Common Medical Events chart below for your costs for services this plan covers. Out-of-network: 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, the family deductible is met by adding the total amount of deductible expenses paid by all family members; however, no one family member can contribute more than the individual deductible amount.
Are there services covered before you meet your deductible?	Yes. In-network services, out-of-network emergency room care, out-of-network emergency medical transportation, prescription drugs, vision and dental are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	In-Network: **$3,000**/individual; **$9,000**/family. Out-of-Network: **$3,000**/individual; **$9,000**/family.	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-billing charges and health care this plan does not 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 1-800-639-2227 or 1-401-459-5000 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.

Important Questions	Answers	Why this Matters:
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 and 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 copay/visit	$20 copay/visit plus 20% coinsurance	No charge for in-network telemedicine services.
	Specialist visit	$30 copay/visit	$30 copay/visit plus 20% coinsurance	None
	Preventive care/screening/ immunization	No charge	20% coinsurance for immunizations/screenings, contraceptives and breast pumps; $20 or $30 copay/certain preventive services plus 20% coinsurance	Out-of-network copay applies to annual physical exam and pediatric exam, well woman visit, and preventive counseling and education. 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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Preauthorization is recommended for certain services
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	
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: 20% coinsurance; $100 maximum per prescription Mail order: 20% coinsurance; $250 maximum per prescription	Not Covered	Deductible does not apply. No charge for certain preventive drugs. Maximum supply: Retail: 30 days or 100 units, Mail order: 90 days or 300 units. Your cost for a 30-day supply of all insulin drugs is limited to $40. Maximums do not apply for infertility drugs. Preauthorization is required for certain drugs or no benefits provided.
	Tier 2: generally high cost generic and preferred brand name drugs			
	Tier 3: non-preferred brand name drugs			
	Tier 4: specialty drugs	20% coinsurance; $100 maximum per prescription	50% coinsurance; 20% coinsurance for infertility drugs.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Preauthorization is recommended
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$200 copay/visit	$200 copay/visit; Deductible does not apply	Copay waived if admitted
	Emergency medical transportation	$50 copay/trip	$50 copay/trip; Deductible does not apply	None
	Urgent care	$50 copay/visit	$50 copay/visit plus 20% coinsurance	Applies to the visit only. If additional services are provided, additional out-of-pocket costs would apply based on services received.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	45 days/year limit at an inpatient physical rehabilitation facility; Preauthorization is recommended
	Physician/surgeon fee	No charge	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/ office visit; No charge for other outpatient services	$20 copay/office visit plus 20% coinsurance; 20% coinsurance for other outpatient services	Preauthorization is recommended for certain services. Notice of admission and discharge required for the following out-of-network services: non-urgent inpatient services, partial hospitalization, intensive outpatient services, transcranial magnetic stimulation, home- and community-based adult intensive services, and child and family intensive treatment. No charge for in-network telemedicine services.
	Inpatient services	No charge	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge, except $30 copay/office visit for initial office visit to diagnose pregnancy	20% coinsurance, except $30 copay/office visit plus 20% coinsurance for initial office visit to diagnose pregnancy	Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Includes coverage for certified Doula services. Preauthorization is recommended for admissions exceeding 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Preauthorization is recommended
	Rehabilitation services	Inpatient: No charge Outpatient: 20% coinsurance No charge for services to treat autism spectrum disorder	20% coinsurance	Inpatient rehabilitation: limit 45 days/year. Preauthorization of physical, occupational and speech therapy is recommended.
	Habilitation services			
	Skilled nursing care	No charge	20% coinsurance	Custodial care is not covered; Preauthorization is recommended
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization is recommended for certain equipment
	Hospice service	No charge	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and 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	$10 copay/visit through Davis Vision; $30 copay/visit through BCBSRI.	You pay 100% and apply for reimbursement through Davis Vision of up to $40 allowed amount; $30 copay/visit plus 20% coinsurance through BCBSRI. Deductible does not apply under Davis Vision.	Limit: One routine eye exam/12 months under Davis Vision and one routine eye exam per plan year under BCBSRI.
	Children's glasses	$10 copay/lenses. No charge up to $200 for frames ($250 for Visionworks), plus 20% discount on excess of allowed amount. No charge up to $200 for contact lenses, plus 15% discount on excess of allowed amount.	You pay 100% and apply for reimbursement up to allowed amount. Deductible does not apply.	Limit: 1 pair glasses/12 months or 4 disposable boxes of contact lenses/12 months or 2 boxes replacement contact lenses. No charge if the frame is selected from Davis Vision Exclusive Collection. Separately administered by Davis Vision.
	Children's dental check-up	No charge	You pay 100% and apply for reimbursement of up to 100% of allowed amount for services obtained in Rhode Island; 90% for services obtained outside Rhode Island. Deductible does not apply.	Limit: one exam per year

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
- Long-term care
- Routine foot care (unless to treat diabetes or systemic conditions such as metabolic, neurologic, or peripheral vascular disease)
- Weight loss programs (except as required by ACA)

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

- Acupuncture (limit: 12 visits/year)
- Bariatric Surgery
- Chiropractic care (limit: 12 visits/year)
- Dental care (Adult) (limit: $2,000/calendar year and $2,000 lifetime maximum for orthodontia)
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S. (see www.BCBSRI.com)
- Private-duty nursing
- Routine eye care (Adult) (limit: 1 exam/12 months and 1 pair glasses/12 months) (through Davis Vision)

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 those agencies is: The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 on how 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 1-401-459-5000 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 1-401-462-9520 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 1-800-639-2227.

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	$0
Specialist copayment	$30
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$90**

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	$30
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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

The plan's overall deductible	$0
Specialist copayment	$30
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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