



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 1-866-987-3705 or (401) 429-2104 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 1-866-987-3705 or TDD 711 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	For In Network providers \$1000 for an individual plan / \$2000 for a family plan. For Out-of-Network providers \$2000 for an individual plan / \$4000 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 most preventive services, services with a fixed dollar copay, diagnostic testing and ambulance 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>?	For In Network providers \$2000 for an individual plan / \$4000 for a family plan. For Out-of-Network providers \$6000 for an individual plan / \$12000 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 1-866-987-3705 or (401) 429-2104 for a list of <u>network providers</u> .	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 <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 still see a specialist without a referral, however, your costs associated with the office visit may be higher.



- 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	\$15 copay; deductible does not apply per visit	30% coinsurance	Telemedicine visit: \$15 copay; deductible does not apply. If you receive services in addition to office visit, additional deductibles or coinsurance may apply.
	Specialist visit	\$25 copay with referral; deductible does not apply per visit \$50 copay without referral; deductible does not apply per visit	30% coinsurance	\$15 copay; deductible does not apply for Chiropractic Services and PCP referral not required. It's important that you get an electronic referral from your PCP before you see a network specialist. You can still see a specialist without a referral, however, your costs associated with the office visit may be higher.
	Preventive care/screening/immunization	No Charge; deductible does not apply	30% coinsurance	Member liability for In Network is based on services received. 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. 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	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	CT scans, PET scans, MRIs, MRAs, nuclear medicine, and major diagnostic services received at a network freestanding facility covered in full after the deductible has been met.
If you need drugs to treat your illness or condition	Tier 1 generally low cost generic drugs	Retail: \$10 Copay Mail Order: \$20 Copay	Retail: \$10 Copay Mail Order: N/A	

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)	
	Tier 2 generally high cost generic and preferred brand name drugs	Retail: \$35 Copay Mail Order: \$70 Copay	Retail: \$35 Copay Mail Order: N/A	Pharmacy coverage administered by CVS Caremark. Deductible does not apply to prescription drug copays. Retail-31 days/Mail Order-90 days. Specialty Tier 1 Drugs are covered at Tier 1 level.
	Tier 3 non-preferred brand name drugs	Retail: \$60 Copay Mail Order: \$120 Copay	Retail: \$60 Copay Mail Order: N/A	
	Tier 4 specialty prescription drugs	Retail: \$100 Copay Mail Order: Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply.
If you need immediate medical attention	Emergency room care	\$150 copay; deductible does not apply per visit	\$150 copay; deductible does not apply per visit	Emergency room: Copay waived if admitted; Urgent care: Applies to the visit only. If additional services are provided additional out of pockets costs would apply based on services received.
	Emergency medical transportation	No Charge; deductible does not apply per trip	No Charge; deductible does not apply per trip	
	Urgent care	\$50 copay; deductible does not apply per urgent care center visit	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	See www.employeebenefits.ri.gov for list of services requiring prior authorization. Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply.

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)	
	Physician/surgeon fee	10% coinsurance	30% coinsurance	Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 copay; deductible does not apply/office visit 10% coinsurance for outpatient services	30% coinsurance/office visit 30% coinsurance for outpatient services	3 EAP visits per diagnosis.
	Inpatient services	10% coinsurance	30% coinsurance	
If you are pregnant	Office visits	\$15 copay/initial visit only; deductible does not apply	30% 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).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	No visit limit. Custodial, domiciliary and respite care are not covered. Prior authorization required.
	Rehabilitation services	\$15 copay; deductible does not apply	30% coinsurance	

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)	
	Habilitation services	\$15 copay; deductible does not apply	30% coinsurance	Certain services for a Dependent child younger than 3 years of age who is certified by the RI Department of Human Services (DHS) as eligible for early intervention services. Services must be provided by a licensed provider designated by the RI DHS as an "early intervention provider" and who works in early intervention programs approved by the RI Department of Health. Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply.
	Skilled nursing care	10% coinsurance	30% coinsurance	Non-Network requires prior authorization; Custodial care is not covered
	Durable medical equipment	10% coinsurance	30% coinsurance	Non-Network prior authorization required for certain services; Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply.
	Hospice service	10% coinsurance	30% coinsurance	No visit or dollar limit. Non-network prior authorization required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Medically necessary exams: In Network: \$25 copay; deductible does not apply, Out of Network: 30% coinsurance.
	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.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up, child
- Glasses, child
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Child)
- 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.

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 1-866-987-3705 or (401) 429-2104 or TDD 711, state insurance department at (401) 462-9520 or by email at HealthInquiry@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 1-866-987-3705 or (401) 429-2104 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 HealthInquiry@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 1-866-987-3705.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-987-3705.

如果需要中文的帮助, 请拨打这个号码 1-866-987-3705.

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-987-3705.

————— *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 **\$1000**
- Specialist copayment **\$25**
- Hospital (facility) coinsurance **10%**
- Other coinsurance **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 **\$12,800**

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$0
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$100
The total Peg would pay is	\$2,100

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

- The plan's overall deductible **\$1000**
- Specialist copayment **\$25**
- Hospital (facility) coinsurance **10%**
- Other coinsurance **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 **\$7,400**

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$100
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$4,800
The total Joe would pay is	\$5,920

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

- The plan's overall deductible **\$1000**
- Specialist copayment **\$25**
- Hospital (facility) coinsurance **10%**
- Other coinsurance **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 **\$1,900**

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,200

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