



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 <u>deductible</u>? | For In Network providers \$500 for an individual plan / \$1000 for a family plan. For Out-of-Network providers \$1000 for an individual plan / \$2000 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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u>? | Yes. Doesn't apply to preventive services, services with a fixed dollar copay, prescription drugs and diagnostic testing. | 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 \$1500 for an individual plan / \$3000 for a family plan. For Out-of-Network providers \$3000 for an individual plan / \$6000 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, they have to meet their own <u>out-of-pocket limits</u> until the overall family out-of-pocket limit has been 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 1-800-639-2227 or (401) 459-5000 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 see the <u>specialist</u> 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 <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$20 copay; deductible does not apply per visit | 20% coinsurance | None |
| | Specialist visit | \$30 copay; deductible does not apply per visit | 20% coinsurance | Chiropractic Services are limited to 12 visit(s) per year |
| | Preventive care/screening/immunization | No Charge; deductible does not apply | 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; deductible does not apply | 20% coinsurance | Preauthorization is recommended for certain services |
| | Imaging (CT/PET scans, MRIs) | No Charge | 20% coinsurance | |

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|---|---|--|--|---|
| | | In Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.BCBSRI.com . | Tier 1 generally low cost generic drugs | \$10 copay; deductible does not apply per prescription (retail) \$25 copay; deductible does not apply per prescription (mail-order) | Not Covered | No charge for certain preventive drugs; Preauthorization is required for certain drugs; Infertility drugs: 20% coinsurance; deductible does not apply |
| | Tier 2 generally high cost generic and preferred brand name drugs | \$20 copay; deductible does not apply per prescription (retail) \$50 copay; deductible does not apply per prescription (mail-order) | Not Covered | |
| | Tier 3 non-preferred brand name drugs | \$30 copay; deductible does not apply per prescription (retail) \$75 copay; deductible does not apply per prescription (mail-order) | Not Covered | |
| | Tier 4 specialty prescription drugs | \$50 copay; deductible does not apply per prescription (Specialty pharmacy) | 50% coinsurance; deductible does not apply | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No Charge | 20% coinsurance | Preauthorization is recommended; Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply. |
| | Physician/surgeon fees | No Charge | 20% coinsurance | Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply. |

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|--|---|---|---|--|
| | | 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 | \$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 pocket costs would apply based on services received. |
| | Emergency medical transportation | \$50 copay; deductible does not apply per trip | \$50 copay; deductible does not apply per trip | |
| | Urgent care | \$30 copay; deductible does not apply per urgent care center visit | \$30 copay; deductible does not apply per urgent care center visit | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No Charge | 20% coinsurance | Preauthorization is recommended; 45 day limit at an inpatient rehabilitation facility; Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply. |
| | Physician/surgeon fee | No Charge | 20% 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 | \$20 copay; deductible does not apply/office visit No Charge for outpatient services | 20% coinsurance/office visit 20% coinsurance for outpatient services | Preauthorization is recommended for certain services |
| | Inpatient services | No Charge | 20% coinsurance | |
| If you are pregnant | Office visits | \$30 copay; deductible does not apply 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 | 20% coinsurance | |
| | Childbirth/delivery facility services | No Charge | 20% coinsurance | |

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|---|----------------------------|---|--|--|
| | | In Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | No Charge | 20% coinsurance | Preauthorization is recommended |
| | Rehabilitation services | 20% coinsurance | 20% coinsurance | Services include Physical, Occupational and Speech Therapy; limited to 30 visits each (combined for in and out of network). No Charge for services to treat autism spectrum disorder and are not subject to visit limits. Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply. |
| | Habilitation services | 20% coinsurance | 20% coinsurance | |
| | Skilled nursing care | No Charge | 20% coinsurance | |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | Preauthorization is recommended for certain services. Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply. |
| | Hospice service | No Charge | 20% coinsurance | None |
| If your child needs dental or eye care | Children's eye exam | \$30 copay; deductible does not apply per visit | 20% coinsurance | 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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) | | |
|--|--|---|
| <ul style="list-style-type: none">• Acupuncture• Cosmetic surgery• Dental care (Adult) | <ul style="list-style-type: none">• Dental check-up, child• Glasses, child• Long-term care | <ul style="list-style-type: none">• 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 <u>plan</u> document.) | | |
| <ul style="list-style-type: none">• Bariatric Surgery• Chiropractic care• Hearing aids | <ul style="list-style-type: none">• Infertility treatment• Most coverage provided outside the United States. Contact Customer Service for more information. | <ul style="list-style-type: none">• 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? **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, 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 <u>deductible</u> | \$500 |
| ■ <u>Specialist copayment</u> | \$30 |
| ■ Hospital (facility) <u>coinsurance</u> | No Charge |
| ■ Other <u>coinsurance</u> | 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 | \$500 |
| Copayments | \$40 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$600 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|--|-----------|
| ■ The plan's overall <u>deductible</u> | \$500 |
| ■ <u>Specialist copayment</u> | \$30 |
| ■ Hospital (facility) <u>coinsurance</u> | No Charge |
| ■ Other <u>coinsurance</u> | 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 | \$500 |
| Copayments | \$500 |
| Coinsurance | \$10 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,030 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|--|-----------|
| ■ The plan's overall <u>deductible</u> | \$500 |
| ■ <u>Specialist copayment</u> | \$30 |
| ■ Hospital (facility) <u>coinsurance</u> | No Charge |
| ■ Other <u>coinsurance</u> | 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 | \$500 |
| Copayments | \$300 |
| Coinsurance | \$20 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$820 |

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