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 800-639-2227 or 40-459-5000. 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 www.bcbsri.com or call 800-639-2227 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $2,000/individual; $4,000/family. Out-of-network: $2,000/individual; $4,000/family.	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. Primary care and specialist visits, preventive services, diagnostic tests and imaging, prescription drugs, emergency room care, emergency medical transportation, urgent care, durable medical equipment and vision care 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: $4,000/individual; $8,000/family. Out-of-network: $4,000/individual; $8,000/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 doesn't 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 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
		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/visit. Deductible does not apply.	20% coinsurance.	None.
	Specialist visit			
	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 you need are preventive. Then check what your plan will pay for. Age and frequency limits apply.
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)			
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsri.com	Generic drugs	20% coinsurance/retail and mail order. Deductible does not apply.	20% coinsurance/retail and mail order. Deductible does not apply.	Retail: limit 30-day supply. Mail order: limit 90-day supply. No charge for certain preventive drugs. No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate). Preauthorization is required for certain drugs. Infertility drugs: in-network 20% coinsurance; out-of-network not covered.
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs	20% coinsurance/retail and mail order. Deductible does not apply.	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge.	20% coinsurance.	Preauthorization is recommended.
	Physician/surgeon fees			

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	Emergency room care	$100 copay/visit. Deductible does not apply.	$100 copay/visit. Deductible does not apply.	Copay waived if admitted.
	Emergency medical transportation	$50 copay/trip. Deductible does not apply.	$50 copay/trip. Deductible does not apply.	None.
	Urgent care	$15 copay/visit. Deductible does not apply.	$15 copay/visit. Deductible does not apply.	Additional services received may be billed separately.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge.	20% coinsurance.	Preauthorization is recommended. Coverage limited to a semi-private room unless a private room is medically necessary.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/office visit and deductible does not apply. No charge for other outpatient services.	20% coinsurance.	Preauthorization is recommended for certain services.
	Inpatient services	No charge.	20% coinsurance.	Preauthorization is recommended. Coverage limited to a semi-private room unless a private room is medically necessary.
If you are pregnant	Office visits	$15 copay/first visit. Subsequent visits: no charge. Deductible does not apply.	20% coinsurance.	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge.	20% coinsurance.	Preauthorization is recommended for stays over 48 hours (96 hours for cesarean delivery).
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	No charge.	20% coinsurance.	None.
	Rehabilitation services	No charge.	20% coinsurance.	Preauthorization is recommended.
	Habilitation services			
	Skilled nursing care	No charge.	20% coinsurance.	Preauthorization is recommended. Custodial care is not covered.

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)	
	Durable medical equipment	20% coinsurance. Deductible does not apply.	20% coinsurance.	Preauthorization is recommended for certain services. No charge for diabetic supplies or outpatient supplies.
	Hospice services	No charge.	20% coinsurance.	Preauthorization is recommended.
If your child needs dental or eye care	Children's eye exam	$15 copay/visit. Deductible does not apply.	20% coinsurance.	Limit: 1 exam/year.
	Children's glasses	Not covered.	Not covered.	You must pay 100% of this service, even in-network.
	Children's dental check-up	Not covered.	Not covered.	You must pay 100% of this service, even in-network.

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
- Children's dental check-up
- Children's glasses
- Cosmetic surgery (except for mastectomy)
- Dental care (Adult)
- Long-term care
- Routine foot care (unless to treat a systemic condition)
- 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.)

- Bariatric surgery
- Chiropractic care (limit: 26 visits/year)
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S. (see www.bcbsri.com)
- Private-duty nursing
- Routine eye care (Adult) (coverage for 1 exam/year only)

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: 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 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 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
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 the 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:
Spanish (Español): Para obtener asistencia en Español, llame al 800-639-2227.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-639-2227.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码800-639-2227.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 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	$2,0000
Specialist copayment	$15
Hospital (facility) cost sharing	$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)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$10
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,070

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

The plan's overall deductible	$2,000
Specialist copayment	$15
Hospital (facility) cost sharing	$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)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,170
Copayments	$90
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	$2,290

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

The plan's overall deductible	$2,000
Specialist copayment	$15
Emergency room copayment	$100
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	$410
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$610

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