




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](http://www.bcbsri.com) or call 800-639-2227 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>In-network</u> : \$0. <u>Out-of-network</u> : \$200/individual; \$600/family.	<u>In-network</u> : See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. <u>Out-of-network</u> : Generally, you must pay all of the costs from <u>providers</u> 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> ?	<u>In-network</u> : N/A. <u>Out-of-network</u> : Yes. <u>Prescription drugs</u> , <u>emergency room care</u> , <u>emergency medical transportation</u> , <u>urgent care</u> , glasses and dental care are covered before you meet your <u>deductible</u> .	<u>In-network</u> : This <u>plan</u> does not have a <u>deductible</u> for <u>in-network</u> services. <u>Out-of-network</u> : This <u>plan</u> covers some items and services even if you haven't met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<u>In-network</u> : \$3,000/individual; \$6,000/family. <u>Out-of-network</u> : \$3,000/individual; \$6,000/family.	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 <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, glasses, dental care and health care this <u>plan</u> 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 <a href="http://www.bcbsri.com">www.bcbsri.com</a> or call 800-639-2227 or 401-459-5000 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). 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 <u>referral</u> /

 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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (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	\$15 <u>copay</u> /visit.	20% <u>coinsurance</u> .	None.
	<u>Specialist</u> visit			
	<u>Preventive care/screening/immunization</u>	No charge.	20% <u>coinsurance</u> .	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for. Age and frequency limits apply.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge.	20% <u>coinsurance</u> .	<u>Preauthorization</u> is recommended for certain services.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.bcbsri.com">www.bcbsri.com</a>	Generic drugs	20% <u>coinsurance</u> /retail and mail order. <u>Deductible</u> does not apply.	20% <u>coinsurance</u> /retail and mail order. <u>Deductible</u> 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). <u>Preauthorization</u> is required for certain drugs. Infertility drugs: <u>in-network</u> 20% <u>coinsurance</u> ; <u>out-of-network</u> not covered.
	Preferred brand drugs			
	Non-preferred brand drugs			
	<u>Specialty drugs</u>	20% <u>coinsurance</u> /retail and mail order. <u>Deductible</u> does not apply.	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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge.	20% <u>coinsurance</u> .	<u>Preauthorization</u> is recommended.
	Physician/surgeon fees			
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit. <u>Deductible</u> does not apply.	\$100 <u>copay</u> /visit. <u>Deductible</u> does not apply.	<u>Copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	None.
	<u>Urgent care</u>	\$15 <u>copay</u> /visit. <u>Deductible</u> does not apply.	\$15 <u>copay</u> /visit. <u>Deductible</u> 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% <u>coinsurance</u> .	<u>Preauthorization</u> is recommended. Coverage limited to a semi-private room unless a private room is <u>medically necessary</u> .
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copay</u> /office visit. No charge for other outpatient services.	20% <u>coinsurance</u> .	<u>Preauthorization</u> is recommended for certain services.
	Inpatient services	No charge.	20% <u>coinsurance</u> .	<u>Preauthorization</u> is recommended. Coverage limited to a semi-private room unless a private room is <u>medically necessary</u> .
If you are pregnant	Office visits	\$15 <u>copay</u> /first visit. Subsequent visits: No charge.	20% <u>coinsurance</u> .	Cost sharing does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge.	20% <u>coinsurance</u> .	<u>Preauthorization</u> 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	<u>Home health care</u>	No charge.	20% <u>coinsurance</u> .	None.
	<u>Rehabilitation services</u>	No charge.	20% <u>coinsurance</u> .	<u>Preauthorization</u> is recommended.
	<u>Habilitation services</u>			

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)	
needs	<u>Skilled nursing care</u>	No charge.	20% <u>coinsurance</u> .	<u>Preauthorization</u> is recommended. Custodial care is not covered.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> .	20% <u>coinsurance</u> .	<u>Preauthorization</u> is recommended for certain services. No charge for diabetic supplies or outpatient supplies.
	<u>Hospice services</u>	No charge.	20% <u>coinsurance</u> .	<u>Preauthorization</u> is recommended.
If your child needs dental or eye care	Children's eye exam	\$15 <u>copay</u> /visit.	20% <u>coinsurance</u> .	Limit: 1 exam/year.
	Children's glasses	No charge. <u>Deductible</u> does not apply.	No charge up to <u>allowed amount</u> . <u>Deductible</u> does not apply.	Limit: 1 pair/glasses every 12 months. Separately administered by Davis Vision.
	Children's dental check-up	No charge. <u>Deductible</u> does not apply.	No charge up to <u>allowed amount</u> . <u>Deductible</u> does not apply.	Limit: 1 exam/year; 2 cleanings/year. Separately administered by Delta Dental of Rhode Island.

#### 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"><li>• Acupuncture</li><li>• Cosmetic surgery (except for mastectomy or <u>medically necessary</u>)</li></ul>	<ul style="list-style-type: none"><li>• Long-term care</li><li>• Routine foot care (unless to treat a systemic condition)</li></ul>	<ul style="list-style-type: none"><li>• Weight loss programs (except as required by ACA)</li></ul>
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"><li>• Bariatric surgery</li><li>• Chiropractic care (limit: 26 visits/year)</li><li>• Dental care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids</li><li>• Infertility treatment</li><li>• Non-emergency care when traveling outside the U.S. (see <a href="http://www.bcbsri.com">www.bcbsri.com</a>)</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine eye care (Adult)</li></ul>

**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](http://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](http://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](http://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](mailto: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, kwijijigo 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 <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> copayment	\$15
■ Hospital (facility) <u>cost sharing</u>	\$0
■ 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	\$12,800
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$20
<u>Coinsurance</u>	\$10
<i>What isn't covered</i>	
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 <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> copayment	\$15
■ Hospital (facility) <u>cost sharing</u>	\$0
■ 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	\$7,400
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$90
<u>Coinsurance</u>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$30
The total Joe would pay is	\$1,320

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> copayment	\$15
■ Emergency room <u>copayment</u>	\$100
■ 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	\$1,900
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$240