**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 deductible?** | Combined deductible for In Network and Out-of-Network providers **$100** for an individual plan / **$200** for a family plan. | 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.<br>Doesn't apply to preventive services, services with a fixed dollar copay, prescription drugs, diagnostic testing, imaging services, infertility services, inpatient services and some outpatient services. | 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 deductible for specific services. |
| **What is the out-of-pocket limit for this plan?** | Combined out-of-pocket limit for In Network and Out-of-Network- providers **$6350** for an individual plan / **$12700** for a family plan. | 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-billed 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 1-800-639-2227 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 |
|---|---|---|---|---|
| | | 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% coinsurance | 20% coinsurance | None |
| | Specialist visit | 20% coinsurance | 20% coinsurance | None |
| | Preventive care/screening/immunization | No Charge; deductible does not apply | 20% coinsurance | Member liability for Out-of-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.<br>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 | No Charge; deductible does not apply | Preauthorization is recommended for certain services |
| | Imaging (CT/PET scans, MRIs) | No Charge; deductible does not apply | 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) | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.BCBSRI.com. | Tier 1 generally low cost generic drugs | 20% coinsurance; deductible does not apply (retail & 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% coinsurance; deductible does not apply (retail & mail order) | Not Covered | |
| | Tier 3 non-preferred brand name drugs | 20% coinsurance; deductible does not apply (retail & mail order) | Not Covered | |
| | Tier 4 specialty prescription drugs | 20% coinsurance; deductible does not apply (Specialty pharmacy);<br>50% coinsurance; deductible does not apply (retail) | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No Charge; deductible does not apply | No Charge; deductible does not apply | 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; deductible does not apply | No Charge; deductible does not apply | 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 | $25 copay; deductible does not apply per visit | $25 copay; deductible does not apply per visit | Emergency room: Copay waived if admitted |
| | Emergency medical transportation | $50 copay; deductible does not apply per trip | $50 copay; deductible does not apply per trip | |
| | Urgent care | 20% coinsurance | 20% 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) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No Charge; deductible does not apply | No Charge; deductible does not apply | 45 day limit at an inpatient rehabilitation facility; Preauthorization is recommended. Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply. |
| | Physician/surgeon fee | No Charge; deductible does not apply | No Charge; deductible does not apply | 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% coinsurance/office visit<br>No Charge; deductible does not apply for outpatient services | 20% coinsurance/office visit<br>No Charge; deductible does not apply for outpatient services | Preauthorization is recommended for certain services |
| | Inpatient services | No Charge; deductible does not apply | No Charge; deductible does not apply | |
| **If you are pregnant** | Office visits | 20% coinsurance | 20% 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). Preauthorization is recommended. |
| | Childbirth/delivery professional services | No Charge; deductible does not apply | No Charge; deductible does not apply | |
| | Childbirth/delivery facility services | No Charge; deductible does not apply | 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) | |
| **If you need help recovering or have other special health needs** | Home health care | No Charge; deductible does not apply | No Charge; deductible does not apply | Preauthorization is recommended<br>Private duty nursing: 20% coinsurance |
| | Rehabilitation services | 20% coinsurance | 20% coinsurance | Includes Physical, Occupational and Speech Therapy; Services to treat autism spectrum disorder; In Network and Out of Network: No Charge; deductible does not apply. 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; deductible does not apply | No Charge; deductible does not apply | Custodial care is not covered;<br>Preauthorization is recommended |
| | 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; deductible does not apply | No Charge; deductible does not apply | None |
| **If your child needs dental or eye care** | Children's eye exam | $10 copay; deductible does not apply per visit | $10 copay; deductible does not apply per visit | Limited to one routine eye exam per year. Medically necessary exams are covered at 20% coinsurance |
| | Children's glasses | 100% of provider charge; deductible does not apply | 100% of provider charge; deductible does not apply | Limited to $50 per member age 0 - 18 per occurrence/$50 per member age 19 and over per year for prescription glasses (frames and/or lenses) or contact lenses. |
| | 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.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up, child
- Long-term care
- 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.
- 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.**
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 1-800-639-2227.

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** | **$100** |
| **Specialist copayment** | **$0** |
| **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** | **$12,800** |

**In this example, Peg would pay:**

| | |
|---|---|
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $10 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$70** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$100** |
| **Specialist copayment** | **$0** |
| **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** | **$7,400** |

**In this example, Joe would pay:**

| | |
|---|---|
| *Cost Sharing* | |
| Deductibles | $100 |
| Copayments | $0 |
| Coinsurance | $1,300 |
| *What isn't covered* | |
| Limits or exclusions | $30 |
| **The total Joe would pay is** | **$1,430** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$100** |
| **Specialist copayment** | **$0** |
| **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** | **$1,900** |

**In this example, Mia would pay:**

| | |
|---|---|
| *Cost Sharing* | |
| Deductibles | $100 |
| Copayments | $80 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$280** |

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

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# Nondiscrimination and Language Assistance

Blue Cross & Blue Shield of Rhode Island (BCBSRI) complies with applicable Federal civil rights laws and does not discriminate or treat people differently on the basis of race, color, national origin, age, disability, or sex.

BCBSRI provides free aids and services to people with disabilities and to people whose primary language is not English when such services are necessary to communicate effectively with us.

If you need these services, contact us at 800-639-2227.

If you believe that BCBSRI has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Director of Grievance and Appeals Department, Blue Cross & Blue Shield of Rhode Island, 500 Exchange Street, Providence RI 02903, or by calling 401-459-5000 or 800-639-2227 (TTY/TDD: 888-252-5051). You can file a grievance in person, by phone or by mail, fax at 401-459-5005, or electronically through our member portal at bcbsri.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

**English:** If you, or someone you're helping, has questions about Blue Cross & Blue Shield of Rhode Island, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-639-2227.

**Spanish:** Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross & Blue Shield of Rhode Island, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-639-2227.

**Portuguese:** Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue Cross & Blue Shield of Rhode Island, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-800-639-2227.

**Chinese:** 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross & Blue Shield of Rhode Island 方面 的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話在此插入數字 1-800-639-2227.

**French Creole:** Si oumenm oswa yon moun w ap ede gen kesyon konsènan Blue Cross & Blue Shield of Rhode Island, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-800-639-2227.

**Cambodian-Mon-Khmer:** ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងតែជួយ មានសំណួរអំពី Blue Cross & Blue Shield of Rhode Island ទេ, អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មាន នៅក្នុងភាសា របស់អ្នក ដោយមិនអស់ប្រាក់ ។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូម 1-800-639-2227.

**French:** Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross & Blue Shield of Rhode Island, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-639-2227.

**Italian:** Se tu o qualcuno che stai aiutando avete domande su Blue Cross & Blue Shield of Rhode Island, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-639-2227.

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**Laotian:** ຖ້າທ່ານ, ຫຼືຄົນທີ່ທ່ານກ່າວເຖິງຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບ Blue Cross & Blue Shield of Rhode Island, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-800-639-2227.

**Arabic:** إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross & Blue Shield of Rhode Island، فلديك الحق في الحصول على المساعدة و المعلومات الضرورية بلغتك من دون اية تكلفة.
للتحدث مع مترجم اتصل بـ 1-800-639-2227.

**Russian:** Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross & Blue Shield of Rhode Island, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-639-2227.

**Vietnamese:** Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross & Blue Shield of Rhode Island, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-639-2227.

**Kru:** I bale we, tole mut u ye hola, a gwee mbarga inyu Blue Cross & Blue Shield of Rhode Island, U gwee Kunde I kosna mahola ni biniiguene I hop wong nni nsaa wogui wo. I Nyu ipot ni mut a nla koblene we hop, sebel 1-800-639-2227.

**Ibo:** Ọ bụrụ gị, ma o bụ onye I na eyere-aka, nwere ajụjụ gbasara Blue Cross & Blue Shield of Rhode Island, I nwere ohere iwenta nye maka na ọmụma na asụsụ gị na akwu gị ụgwọ. I chọrọ I kwụrụ onye-ntapịa okwu, kpọ 1-800-639-2227.

**Yoruba:** Bí ìwọ, tàbí ẹnikẹni tí o n ranlọwọ, bá ní ibeere nípa Blue Cross & Blue Shield of Rhode Island, o ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó.
Láti bá ongbufọ kan sọrọ, pè sórí 1-800-639-2227.

**Polish:** Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Blue Cross & Blue Shield of Rhode Island, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-639-2227.

**Korean:** 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Blue Cross & Blue Shield of Rhode Island 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-800-639-2227 로 전화하십시오.

**Tagalog:** Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross & Blue Shield of Rhode Island, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-800-639-2227.

This notice is being provided to you in compliance with federal law.

Blue Cross Blue Shield of Rhode Island
www.bcbsri.com

500 Exchange Street • Providence, RI 02903-2699

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