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.

What is the out-of-pocket limit for this plan?	For In Network providers $6850 for an individual plan / $13700 for a family plan. For Out-of-Network providers $13700 for an individual plan / $27400 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?	Yes	This plan will pay some of all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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 More information about prescription drug coverage is available at www.BCBSRI.com.	Tier 1 generally low cost generic drugs	$7 copay; deductible does not apply per prescription (retail) $17.50 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	$25 copay; deductible does not apply per prescription (retail) $62.50 copay; deductible does not apply per prescription (mail-order)	Not Covered	
	Tier 3 non-preferred brand name drugs	$40 copay; deductible does not apply per prescription (retail) $100 copay; deductible does not apply per prescription (mail-order)	Not Covered	
	Tier 4 specialty prescription drugs	$65 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.

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 immediate medical attention	Emergency room care	$200 copay; deductible does not apply per visit	$200 copay; deductible does not apply per visit	Emergency room: Copay waived if admitted; Air/Water Ambulance: No Charge; 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	$50 copay; deductible does not apply per urgent care center visit	$50 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		

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important

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
- Glasses, 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

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.

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To see examples of how this plan might cover costs for a sample medical situation, see the next section.