all 1-800-639-2227 or (401) 459-

[redacted]

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?	For In Network providers $6000 for an individual plan / $12000 for a family plan. For Out-of-Network providers $10000 for an individual plan / $20000 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. Doesn't apply to preventive services, services with a fixed dollar copay, prescription drugs, diagnostic testing and vision care services.	This plan covers ¦ o 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?	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-

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	$30 copay; deductible does not apply per visit	20% coinsurance	None
	Specialist visit	$50 copay; deductible does not apply per visit	20% coinsurance	Chiropractic Services are limited to 20 visit(s) per year
	Preventive care/screening/immunization	No Charge; deductible does not apply	20% coinsurance	You may have to pay for services that

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 $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;

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; 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			

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