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

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 Import Information
		In Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most	
If you visit a health care S U R Y bfGi He U 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 v per year
	Preventive care/screening/immunizatio	No Charge; deductible does not apply	20% coinsurance	You may have to pay for servicesD tbaHt C preventive. Ask your provider if the serv needed are preventive. Then check wha plan will pay for. For additional details, please see your p 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	20% coinsurance	Preauthorization is recommended for ce services
	Imaging (CT/PET scans, MI	No Charge	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Import 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; deductib does not apply per vi	Emergency room: Copay waived if admitted;

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Import 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	20% coinsurance	Preauthorization is recommended
	Rehabilitation services	20% coinsurance	20% coinsurance	Services include Physical, Occupational a Speech Therapy; No Charge for services to treat autism spectrum disorder; Some In-Network services related to RI Mastecto Treatment Mandate are covered at No C deductible does not apply.
	Habilitation services	20% coinsurance	20% coinsurance	
	Skilled nursing care	No Charge	20% coinsurance	Preauthorization is recommended; Custodial care is not covered
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization is recommended for certai services. Some In-Network services related

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‡ Bariatric Surgery	‡ Infertility treatment	‡ Private-duty nursing
‡ Chiropractic care	‡ Most coverage provided outside the Unit... States. Contact Customer Service for mo... information.	‡ Routine eye care (Adult)
‡ Hearing aids		

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: 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, 'HSDUWPHQW RI /DERU¶V (PSOR\HH %HQHILWV 6HFXULW\ $GPLQLVWUDWLRQ 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 assistan... contact: contact the plan at 1-800-639-2227 or (401) 459-... RU 7'' ... <RX PD\ DOVR FRQWDFW WKH 'HSDUWPHQW... Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Co... your state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes

If your plan GRHVQ¶W PHHW WKH Minimum Value Standards, you may be eligible for a

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

0DQDJLQJ -RH·V W\
(a year of routine in-network care of a well-controlled condition)

0LD·V 6LPSOH)U
(in-network emergency room visit and foll care)

- The S O D Q ·V overall deductible $7000
- Specialist copayment $50
- Hospital (facility) coinsurance
- Other coinsurance 20%

This EXAMPLE event includes services like:
Specialist office visits (pre-natal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)

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