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, 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/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: $6000 for an individual plan / $12000 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 for a fixed dollar copay, prescription drugs, diagnostic testing, imaging services, and outpatient mental health services.	This plan F R Y H U V V R P H L W H P V D Q G V H U Y L F deductible amount. But copayment before you meet your

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 b f C e l U or clinic	Primary care visit to treat a injury or illness	$25 copay; deductible d		

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)	

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 immediat medical attention	Emergency room care	$150 copay; deductible does not apply per visit	$150 copay; deductibl does not apply per vis	Emergency room: Copay waived if adm Urgent care: Applies to the visit only. If additional services are provided additional o of pocket costs would apply based on services received.
	Emergency medical transportation	$50 copay; deductible d not apply per trip	$50 copay; deductible does not apply per trip	

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 are pregnant				

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 your child needs dental or eye care	& K L O G U H Q ¶ V H \	$40 copay; deductible d(		

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 your medical claim. Your plan documents also provide complete information to submit a claim, appeal, or 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-[illegible] R U 7 ' ' < R X P D \ D O V R F R Q W D F W W K H ' H S D U W P H Q W Administration at 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-[illegible] 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 G R H V Q ¶ W P H H W 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.

1-800-639-2227.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 1-800-639-2227.

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