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 (401) 331-9191 or visit us at www.iuoelocal57.org. 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 (800) 639-2227 or (401) 459-5000 or TDD 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network and Out-of-network: **$250**/individual; **$500**/family.	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. The following in-network services are covered before you meet your deductible: primary care and specialist office visits, preventive services, diagnostic tests and imaging, urgent care, prescription drugs, outpatient mental health and substance abuse services, and services treating autism spectrum disorder. The following in-network and out-of-network services are covered before you meet your deductible: emergency room care, emergency medical transportation, dental care and eye care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: None. Out-of-network: **$4,000**/individual; **$8,000**/family.	In-network: This plan does not have an out-of-pocket limit on your in-network expenses. Out-of-network: The out-of-pocket limit is the most you could pay in a year for out-of-network 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?	In-network expenses, out-of-network emergency room care, out-of-network emergency medical transportation, out-of-network durable medical equipment, deductibles, copays, premiums, balance-billing 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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.bcbsri.com or call (800) 639-2227 or (401) 459-5000 or TDD 711 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
		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	$15 copay/visit. Deductible does not apply. Includes telemedicine visits with BCBSRI network providers. No charge for telemedicine visits through SwiftMD. Deductible does not apply.	$15 copay/visit, plus 20% coinsurance. Balance-billing charges may apply.	None.
	Specialist visit	$25 copay/visit. Deductible does not apply.	$25 copay/visit, plus 20% coinsurance. Balance-billing charges may apply.	None.
	Preventive care/screening/ Immunization	No charge. Deductible does not apply.	$15 copay/visit for PCP; $25 copay/visit for specialist; plus 20% coinsurance. Balance-billing charges may apply.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Limit: 1 physical and 1 gynecological exam/year. Pediatric preventive care limited according to federal guidelines. Adult, pediatric and travel immunizations covered with no charge.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	No charge. Deductible does not apply.	20% coinsurance. Balance-billing charges may apply.	Preauthorization is recommended or partial/total denial of your claim is possible.
	Imaging (CT/PET scans, MRIs)	No charge. Deductible does not apply.	20% coinsurance. Balance-billing charges may apply.	Preauthorization is recommended or partial/total denial of your claim is possible.
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)	20% coinsurance.	Not covered.	Deductible does not apply. Retail limit: 30 days/100 units. Mail order limit: 90 days/300 units. Generic drugs are mandatory when available or you pay the difference in costs. Your cost for a 30-day supply of all insulin drugs is limited to $40. Mail order pharmacy services provided by Express Scripts Home Delivery.
	Tier 2 (generally high cost generic and preferred brand name drugs)			
	Tier 3 (non-preferred brand name drugs)			
	Tier 4 (specialty drugs)	20% coinsurance (specialty pharmacy); 50% coinsurance (retail pharmacy).	Not covered.	Deductible does not apply. $200 maximum charge per prescription at in-network specialty pharmacy; $200 maximum does not apply to infertility drugs. Accredo is designated as the specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge.	20% coinsurance. Balance-billing charges may apply.	Preauthorization is recommended or partial/total denial of your claim is possible. Some in-network services related to RI Mastectomy Treatment Mandate are covered at no charge; deductible does not apply.
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	$100 copay/visit. Deductible does not apply.	$100 copay/visit. Deductible does not apply.	Copay waived if admitted. Covers visit only; additional services may be billed separately.
	Emergency medical transportation	$50 copay/trip. Deductible does not apply.	$50 copay/trip. Deductible does not apply.	Limit: $3,000 per trip for air or water ambulance. Must be medically necessary.
	Urgent care	$25 copay/visit. Deductible does not apply.	$25 copay/visit; 20% coinsurance. Balance-billing charges may apply.	Covers visit only; additional services may be billed separately.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge.	20% coinsurance. Balance-billing charges may apply.	Preauthorization is recommended or partial/total denial of your claim is possible. Some in-network services related to RI Mastectomy Treatment Mandate are covered at no charge; deductible does not apply. Rehabilitation facility: limit 45 days/year.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/office visit; Other outpatient services: No charge. Deductible does not apply.	$15 copay/office visit plus 20% coinsurance; Other outpatient services: 20% coinsurance. Balance-billing charges may apply.	Preauthorization is recommended or partial/total denial of your claim is possible. Notice of admission and discharge is required for certain out-of-network services (e.g., intensive outpatient treatment, partial hospitalization).
	Inpatient services	No charge.	20% coinsurance. Balance billing charges may apply.	Preauthorization is recommended or partial/total denial of your claim is possible. Notice of admission and discharge is required for certain out-of-network services (e.g., non-urgent inpatient treatment).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$25 copay/first office visit to diagnose pregnancy, then no charge. Deductible does not apply.	$25 copay/visit and 20% coinsurance for first office visit to diagnose pregnancy, then no charge. Balance-billing charges may apply.	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). Includes coverage for certified Doula services.
	Childbirth/delivery professional services	No charge.	20% coinsurance. Balance-billing charges may apply.	Preauthorization is recommended if hospitalization exceeds 48 hours following a vaginal delivery or exceeds 96 hours following a delivery by cesarean section or partial/total denial of your claim is possible. Includes coverage for certified Doula services.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	No charge.	20% coinsurance. Balance-billing charges may apply.	Private-duty nursing: 20% coinsurance.
	Rehabilitation services	20% coinsurance.	20% coinsurance. Balance-billing charges may apply.	Preauthorization recommended for speech therapy or partial/total denial of your claim is possible; maintenance therapy not covered. In-network autism services: no charge; deductible does not apply; not subject to preauthorization recommendation. Some in-network services related to RI Mastectomy Treatment Mandate are covered at no charge; deductible does not apply.
	Habilitation services			
	Skilled nursing care	No charge.	20% coinsurance. Balance-billing charges may apply.	Preauthorization is recommended or partial/total denial of your claim is possible. Custodial care not covered.
	Durable medical equipment	20% coinsurance.	20% coinsurance. Balance-billing charges may apply.	Preauthorization recommended or partial/total denial of your claim is possible. Some in-network services related to RI Mastectomy Treatment Mandate are covered at no charge; deductible does not apply.
	Hospice services	No charge.	20% coinsurance. Balance-billing charges may apply.	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$25 copay/visit. Deductible does not apply.	$25 copay/visit and 20% coinsurance. Balance-billing charges may apply.	Limit: 1 exam/year.
	Children's glasses	You pay full amount and apply for reimbursement up to allowed amount of $100.	You pay full amount and apply for reimbursement up to allowed amount of $100.	Individuals age 0 – 18: limited to $100 per occurrence; Individuals 19 and over: limited to $100 per year.
	Children's dental check-up	No charge.	No charge up to allowed amount.	Limit: 1 exam and 2 cleanings/year. Maximum: $2,000/individual/year. Individuals under age 19: 1 fluoride treatment/year. Separately administered by Delta Dental of Rhode Island.

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 (except for mastectomy and medically necessary procedures)
- Long-term care
- Routine foot care (unless to treat diabetes or other systemic conditions, such as metabolic, neurologic, or peripheral vascular disease)
- 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 (limit: 12 visits/year)
- Dental care (Adult) (limit: 1 exam/year; 2 cleanings/year; $2,000/member/year)
- Hearing aids (limit: $1,500/hearing aid)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. (see www.bsbcri.com)
- 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 those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 on how 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: For more information about your rights, this notice, or assistance, contact: (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 or the Rhode Island Office of the Health Commissioner at (410) 462-9520 or 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 the 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.

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	$250
Specialist copay	$25
Hospital (facility) cost sharing	$0
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$330**

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

The plan's overall deductible	$250
Specialist copay	$25
Hospital (facility) cost sharing	$0
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$100
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,170**

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

The plan's overall deductible	$250
Specialist copay	$25
Emergency room copay	$100
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$520**

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