




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?	<u>In-network</u> and <u>Out-of-network</u> : \$250 /individual; \$500 /family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. The following <u>in-network</u> services are covered before you meet your <u>deductible</u> : primary care and <u>specialist</u> office visits, <u>preventive services</u> , <u>diagnostic tests</u> and imaging, <u>urgent care</u> , <u>prescription drugs</u> , outpatient mental health and substance abuse services, and services treating autism spectrum disorder. The following <u>in-network</u> and <u>out-of-network</u> services are covered before you meet your <u>deductible</u> : <u>emergency room care</u> , <u>emergency medical transportation</u> , dental care and eye care.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	<u>In-network</u> : None. <u>Out-of-network</u> : \$4,000 /individual; \$8,000 /family.	<u>In-network</u> : This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your <u>in-network</u> expenses. <u>Out-of-network</u> : The <u>out-of-pocket limit</u> is the most you could pay in a year for <u>out-of-network</u> covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>In-network</u> expenses, <u>out-of-network emergency room care</u> , <u>out-of-network emergency medical transportation</u> , <u>out-of-network durable medical equipment</u> , <u>deductibles</u> , <u>copays</u> , <u>premiums</u> , <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

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. <u>Deductible</u> does not apply.	20% <u>coinsurance</u> . <u>Balance-billing</u> charges may apply.	<u>Preauthorization</u> is recommended or partial/total denial of your <u>claim</u> is possible.
	Imaging (CT/PET scans, MRIs)	No charge. <u>Deductible</u> does not apply.	20% <u>coinsurance</u> . <u>Balance-billing</u> charges may apply.	<u>Preauthorization</u> is recommended or partial/total denial of your <u>claim</u> is possible.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbsri.com	Tier 1 (generally low cost generic drugs)	20% <u>coinsurance</u> .	Not covered.	<u>Deductible</u> 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 (<u>specialty drugs</u>)	20% <u>coinsurance</u> (<u>specialty pharmacy</u>); 50% <u>coinsurance</u> (<u>retail pharmacy</u>).	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge.	20% <u>coinsurance</u> . <u>Balance-billing</u> charges may apply.	<u>Preauthorization</u> is recommended or partial/total denial of your <u>claim</u> is possible. Some <u>in-network</u> services related to RI Mastectomy Treatment Mandate are covered at no charge; <u>deductible</u> 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	<u>Emergency room care</u>	\$100 <u>copay</u> /visit. <u>Deductible</u> does not apply.	\$100 <u>copay</u> /visit. <u>Deductible</u> does not apply.	<u>Copay</u> waived if admitted. Covers visit only; additional services may be billed separately.
	<u>Emergency medical transportation</u>	\$50 <u>copay</u> /trip. <u>Deductible</u> does not apply.	\$50 <u>copay</u> /trip. <u>Deductible</u> does not apply.	Limit: \$3,000 per trip for air or water ambulance. Must be <u>medically necessary</u> .
	<u>Urgent care</u>	\$25 <u>copay</u> /visit. <u>Deductible</u> does not apply.	\$25 <u>copay</u> /visit; 20% <u>coinsurance</u> . <u>Balance-billing</u> 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% <u>coinsurance</u> . <u>Balance-billing</u> charges may apply.	<u>Preauthorization</u> is recommended or partial/total denial of your <u>claim</u> is possible. Some <u>in-network</u> services related to RI Mastectomy Treatment Mandate are covered at no charge; <u>deductible</u> 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 <u>copay</u> /office visit; Other outpatient services: No charge. <u>Deductible</u> does not apply.	\$15 <u>copay</u> /office visit plus 20% <u>coinsurance</u> ; Other outpatient services: 20% <u>coinsurance</u> . <u>Balance-billing</u> charges may apply.	<u>Preauthorization</u> is recommended or partial/total denial of your <u>claim</u> is possible. Notice of admission and discharge is required for certain <u>out-of-network</u> services (e.g., intensive outpatient treatment, partial <u>hospitalization</u>).
	Inpatient services	No charge.	20% <u>coinsurance</u> . <u>Balance billing</u> charges may apply.	<u>Preauthorization</u> is recommended or partial/total denial of your <u>claim</u> is possible. Notice of admission and discharge is required for certain <u>out-of-network</u> 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 <u>copay</u> /first office visit to diagnose pregnancy, then no charge. <u>Deductible</u> does not apply.	\$25 <u>copay</u> /visit and 20% <u>coinsurance</u> for first office visit to diagnose pregnancy, then no charge. <u>Balance-billing</u> charges may apply.	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> 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% <u>coinsurance</u> . <u>Balance-billing</u> charges may apply.	<u>Preauthorization</u> is recommended if <u>hospitalization</u> exceeds 48 hours following a vaginal delivery or exceeds 96 hours following a delivery by cesarean section or partial/total denial of your <u>claim</u> is possible. Includes coverage for certified Doula services.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge.	20% <u>coinsurance</u> . <u>Balance-billing</u> charges may apply.	Private-duty nursing: 20% <u>coinsurance</u> .
	<u>Rehabilitation services</u>	20% <u>coinsurance</u> .	20% <u>coinsurance</u> . <u>Balance-billing</u> charges may apply.	<u>Preauthorization</u> recommended for speech therapy or partial/total denial of your <u>claim</u> is possible; maintenance therapy not covered. <u>In-network</u> autism services: no charge; <u>deductible</u> does not apply; not subject to <u>preauthorization</u> recommendation. Some <u>in-network</u> services related to RI Mastectomy Treatment Mandate are covered at no charge; <u>deductible</u> does not apply.
	<u>Habilitation services</u>			
	<u>Skilled nursing care</u>	No charge.	20% <u>coinsurance</u> . <u>Balance-billing</u> charges may apply.	<u>Preauthorization</u> is recommended or partial/total denial of your <u>claim</u> is possible. Custodial care not covered.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> .	20% <u>coinsurance</u> . <u>Balance-billing</u> charges may apply.	<u>Preauthorization</u> recommended or partial/total denial of your <u>claim</u> is possible. Some <u>in-network</u> services related to RI Mastectomy Treatment Mandate are covered at no charge; <u>deductible</u> does not apply.
	<u>Hospice services</u>	No charge.	20% <u>coinsurance</u> . <u>Balance-billing</u> 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 <u>copay</u> /visit. <u>Deductible</u> does not apply.	\$25 <u>copay</u> /visit and 20% <u>coinsurance</u> . <u>Balance-billing</u> charges may apply.	Limit: 1 exam/year.
	Children's glasses	You pay full amount and apply for reimbursement up to <u>allowed amount</u> of \$100.	You pay full amount and apply for reimbursement up to <u>allowed amount</u> 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 <u>allowed amount</u> .	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Acupuncture Cosmetic surgery (except for mastectomy and <u>medically necessary</u> procedures) 	<ul style="list-style-type: none"> Long-term care Routine foot care (unless to treat diabetes or other systemic conditions, such as metabolic, neurologic, or peripheral vascular disease) 	<ul style="list-style-type: none"> Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> Bariatric surgery Chiropractic care (limit: 12 visits/year) Dental care (Adult) (limit: 1 exam/year; 2 cleanings/year; \$2,000/member/year) 	<ul style="list-style-type: none"> Hearing aids (limit: \$1,500/hearing aid) Infertility treatment 	<ul style="list-style-type: none"> 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 healthinquiry@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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$20
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$800
<i>What isn't covered</i>	
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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$520