

## 100/Not Covered \$2,750 Coinsurance Plan

# Understanding Your Benefits

### ■ **Deductibles**

You pay the following amounts each year before your health plan starts to pay toward the cost of covered services:

- \$2,750 per individual plan;  
\$5,500 per family plan in-network
- Not covered per individual plan;  
Not covered per family plan out-of-network

The deductible has a hybrid calculation, which means that all deductible amounts paid count toward the family deductible, but the individual will never pay more than their individual deductible amount.

### ■ **Out-of-pocket Limits**

The following is the maximum you would pay out-of-pocket for essential health benefits each year (including medical and pharmacy copayments, deductibles, and coinsurance).

- \$2,750 per individual plan;  
\$5,500 per family plan in-network
- Not covered per individual plan;  
Not covered per family plan out-of-network

The out-of-pocket limit has a hybrid calculation, which means that all out-of-pocket amounts paid count toward the family out-of-pocket limit, but the individual will never pay more than their individual out-of-pocket amount.

### ■ **Please note:**

The deductible and out-of-pocket limits are separate for in-network and out-of-network services.

What's covered Service	What you pay	
	In-Network	Out-of-Network
<b>Preventive Care</b> <ul style="list-style-type: none"> <li>■ Adult preventive care</li> <li>■ Child preventive care</li> <li>■ Immunizations</li> <li>■ Preventive lab, X-ray, and imaging</li> </ul>	\$0 per visit	Not Covered
<b>Primary Care Office Visits</b> <ul style="list-style-type: none"> <li>■ Adult primary care</li> <li>■ Adult gynecological exam</li> <li>■ Pediatric primary care</li> </ul>	\$15 per visit for PCMH*	Not Covered
*4 annual visits, subsequent visits apply to the deductible	\$25 per visit for Non PCMH*	
<b>Specialist Office Visits</b> <ul style="list-style-type: none"> <li>■ Specialty care</li> </ul>	\$30 per visit	Not Covered
<b>Chiropractic</b> (limit 20 visits per year)	0% after deductible	Not Covered
<b>Routine eye exam</b> (limit 1 visit per year)	\$40 per visit	Not Covered
<b>Outpatient Services</b> <ul style="list-style-type: none"> <li>■ Diagnostic lab, X-ray, and imaging</li> <li>■ Medical/surgical care</li> <li>■ High-end radiology (e.g., MRI/CT/PET), nuclear medicine, and sleep studies</li> </ul>	0% per visit after deductible	Not Covered

### Beyond Benefits

Sign in to your member page on [bcbsri.com](http://bcbsri.com) for useful plan and wellness information at your fingertips.

#### Access Your Benefits:

- Get a list of your benefits and recent claims.
- See how much you've paid toward your deductible and out-of-pocket maximum.
- Check out our cost and quality tools.
- Find the member handbook to learn what to expect from BCBSRI.

#### Health Topics & Discounts:

- Read about thousands of health topics in the Health Center.
- Learn how you can get discounts on gym memberships, as well as free one-week trial memberships.

### Need help?

#### Call Customer Service

- Locally: (401) 459-5000
- Outside Rhode Island: 1-800-639-2227
- TTY (Telecommunication Device for the Deaf) users should call 711

#### Hours:

Monday – Friday,  
8:00 a.m. to 8:00 p.m.,  
Saturday – Sunday,  
8:00 a.m. to noon  
Eastern Time

What's covered	What you pay	
	Service	In-Network
<b>Inpatient Services</b> <ul style="list-style-type: none"> <li>Hospitalization</li> <li>Maternity</li> <li>Mental health</li> <li>Chemical dependency</li> <li>Rehabilitation (limit 45 days per year)</li> </ul>	0% per visit after deductible	Not Covered
<b>Hospital Emergency Services</b>	0% per visit after deductible	0% per visit after deductible
<b>Urgent Care</b>	0% per visit after deductible	0% per visit after deductible
<b>Telemedicine Visits</b>	\$25 per visit	Not covered
<b>Retail-Based Clinic Visits</b>	\$30 per visit	Not Covered
<b>Ambulance</b> <ul style="list-style-type: none"> <li>Ground</li> </ul>	\$50 per occurrence	\$50 per occurrence
<ul style="list-style-type: none"> <li>Air/Water</li> </ul>	0% per occurrence after deductible	0% per occurrence after deductible
<b>Durable Medical Equipment</b>	0% per service/device after deductible	Not Covered
<b>Physical/Occupational Therapy</b> <ul style="list-style-type: none"> <li>Physical therapy</li> <li>Occupational therapy</li> <li>Speech therapy</li> </ul>	0% per visit after deductible	Not Covered
<b>Pharmacy</b> <ul style="list-style-type: none"> <li>Tier 1 – Low cost generics</li> </ul>	\$10	Not Covered
<ul style="list-style-type: none"> <li>Tier 2 – Mid cost generics</li> </ul>	\$30	
<ul style="list-style-type: none"> <li>Tier 3 – Preferred brand</li> </ul>	0% after deductible	
<ul style="list-style-type: none"> <li>Tier 4 – Non preferred brand</li> </ul>	0% after deductible	
<ul style="list-style-type: none"> <li>Tier 5 - Specialty</li> </ul>	0% after deductible	
<b>Pediatric Vision (For dependents under age 19)</b> <ul style="list-style-type: none"> <li>Collection prescription glasses</li> <li>Standard lenses and lens options</li> <li>Collection contact lenses</li> </ul>	0% per service after deductible	Not Covered

