BasicBlue

Blue Cross Blue Shield of Rhode Island

100/Not Covered $7,150 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:
  - $7,150 per individual plan; $14,300 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).
  - $7,150 per individual plan; $14,300 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	What You Pay	
Service	**In-Network**	**Out-of-Network**
Preventive Care ▪ Adult preventive care ▪ Child preventive care ▪ Immunizations ▪ Preventive lab, X-ray, and imaging	$0 per visit	Not Covered
Primary Care Office Visits ▪ Adult primary care ▪ Adult gynecological exam ▪ Pediatric primary care	$50 per visit for PCMH $70 per visit for Non PCMH	Not Covered
Specialist Office Visits ▪ Specialty care	$85 per visit	Not Covered
Chiropractic (limit 20 visits per year)	0% after deductible	Not Covered
Routine eye exam (limit 1 visit per year)	$95 per visit	Not Covered
Outpatient Services ▪ Diagnostic lab, x-ray, and imaging ▪ Medical/surgical care ▪ High-end radiology (e.g., MRI/CT/PET), nuclear medicine and sleep studies	0% per visit after deductible	Not Covered

continued

Beyond Benefits

Sign in to your member page on BCBSRI.com, and you will have 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/TDD (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 12 p.m., Eastern Time

What's Covered	What You Pay	
Service	**In-Network**	**Out-of-Network**
Inpatient Services ▪ Hospitalization ▪ Maternity ▪ Mental Health ▪ Chemical dependency ▪ Rehabilitation (limit 45 days per year)	0% per visit after deductible	Not Covered
Hospital Emergency Services	0% per occurrence after deductible	0% per occurrence after deductible
Urgent Care	0% per occurrence after deductible	0% per occurrence after deductible
Telemedicine Visits	$40 per visit	Not Covered
Retail Based Clinic Visits	$50 per visit	Not Covered
Ambulance ▪ Ground	$50 per occurrence	$50 per occurrence
▪ Air/Water	0% per occurrence after deductible	0% per occurrence after deductible
Durable Medical Equipment	0% per service/device after deductible	Not Covered
Physical/Occupational Therapy ▪ Physical therapy ▪ Occupational therapy ▪ Speech therapy	0% per visit after deductible	Not Covered
Prescription Drugs ▪ Tier 1 – Low cost generics	$10	Not Covered
▪ Tier 2 – Mid cost generics	$50	Not Covered
▪ Tier 3 – Preferred brand	0% after deductible	Not Covered
▪ Tier 4 – Non preferred brand	0% after deductible	Not Covered
▪ Tier 5 – Specialty	0% after deductible	Not Covered
Pediatric Vision (For dependents under age 19) ▪ Collection prescription glasses ▪ Standard lenses and lens options ▪ Collection contact lenses	0% per service after deductible	Not Covered

This is a summary of your BasicBlue benefits. It is not a contract. For details about your coverage, including any limitations or exclusions not noted here, please refer to your subscriber agreement or call the number located on the back of your BCBSRI ID card. If you have questions about receiving medical care, please call your doctor.

Blue Cross Blue Shield of Rhode Island
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