

100-60+ Copay \$1,500/\$3,000
High Deductible Health Plan
HSA Qualifying

Understanding Your Benefits

Deductibles

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

- \$1,500 per individual plan; \$3,000 per family plan in network
- \$3,000 per individual plan; \$6,000 per family plan out of network
- The deductible has an aggregate calculation which means that all deductible amounts paid count toward the family deductible amount, one or all can meet it.

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).

- \$3,000 per individual plan; \$6,000 per family plan in network
- \$9,000 per individual plan; \$18,000 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
Preventive Care <ul style="list-style-type: none"> Adult preventive care Child preventive care Immunizations Preventive lab, X-ray, and imaging 	\$0 per visit	40% per visit after deductible
Primary Care Office Visits <ul style="list-style-type: none"> Adult primary care Adult gynecological exam Pediatric primary care 	\$5 per visit after deductible For PCMH	40% per visit after deductible
	\$15 per visit after deductible for non-PCMH	
Specialist Office Visits <ul style="list-style-type: none"> Specialty care Chiropractic (limit 20 visits per year) Routine eye exam (limit 1 visit per year) 	\$20 per visit after deductible	40% per visit after deductible
Outpatient Services <ul style="list-style-type: none"> 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	40% per visit after deductible
Inpatient Services <ul style="list-style-type: none"> Hospitalization Maternity Mental Health Chemical dependency Rehabilitation (limit 45 days per year) 	0% per visit after deductible	40% per visit after deductible
Hospital Emergency Services	\$200 per visit after deductible	\$200 per visit after deductible

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

Service	What You Pay	
	In-Network	Out-of-Network
Urgent Care	\$100 per visit after deductible	\$100 per visit after deductible
Telemedicine Visits	0% per visit after deductible	Not Covered
Retail Based Clinic Visits	\$20 per visit after deductible	40% per visit after deductible
Ambulance	\$0 per occurrence after deductible	\$0 per occurrence after deductible
<ul style="list-style-type: none"> Ground Air/Water 	\$0 per occurrence after deductible	\$0 per occurrence after deductible
Durable Medical Equipment	20% per service/device after deductible	40% per service/device after deductible
Physical/Occupational Therapy	\$20 per visit after deductible	40% per visit after deductible
<ul style="list-style-type: none"> Physical therapy Occupational therapy Speech therapy 		
Prescription Drugs	\$10*-Tier 1; \$30*-Tier 2; \$50*-Tier 3; \$75*-Tier 4; \$125*-Tier 5	Not covered
Pediatric Vision (For dependents under age 19)	0% per service after deductible	Not Covered
<ul style="list-style-type: none"> Collection prescription glasses Standard lenses and lens options Collection contact lenses 		

*Applicable once deductible is satisfied



www.bcsri.com

This is a summary of your BlueSolutions 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.

500 Exchange Street • Providence, RI 02903-2699
Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.