

100/60 \$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, and 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).

- \$4,500 per individual plan;  
\$9,000 per family plan in-network
- \$13,500 per individual plan;  
\$27,000 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
<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	40% per visit after deductible
<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>	0% per visit after deductible	40% per visit after deductible
<b>Specialist Office Visits</b> <ul style="list-style-type: none"> <li>▪ Specialty care</li> <li>▪ Chiropractic (limit 20 visits per year)</li> <li>▪ Routine eye exam (limit 1 visit per year)</li> </ul>	0% per visit after deductible	40% per visit after deductible
<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	40% per visit after deductible
<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	40% per visit after deductible

### 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

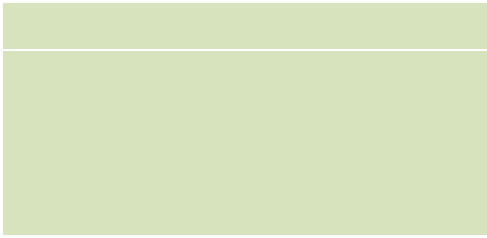
- Locally: (401) 459-5000
- Outside Rhode Island: 1-800-639-2227
- TTY (Telecommunication Device for the Deaf) users should call 711

#### 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	Out-of-Network
<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>		0% per visit after deductible	Not covered
<b>Retail-Based Clinic Visits</b>		0% per visit after deductible	40% per visit after deductible
<b>Ambulance</b>		0% per occurrence after deductible	0% per occurrence after deductible
<ul style="list-style-type: none"> <li>Ground</li> </ul>		0% per occurrence after deductible	0% per occurrence after deductible
<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>		20% per service/device after deductible	40% per service/device after deductible
<b>Physical/Occupational Therapy</b>		0% per visit after deductible	40% per visit after deductible
<ul style="list-style-type: none"> <li>Physical therapy</li> <li>Occupational therapy</li> <li>Speech therapy</li> </ul>		0% per visit after deductible	40% per visit after deductible
<b>Prescription Drugs</b>		\$10*-Tier 1; \$30*-Tier 2; \$50*-Tier 3; \$75*-Tier 4; \$125*-Tier 5	Not covered
<b>Pediatric Vision (For dependents under age 19)</b>		0% per service after deductible	Not covered
<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

\*Applicable once deductible is satisfied.



What's covered	What you pay	
Service	In-Network	Out-of-Network