

100/60 \$1,900/\$3,800
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:

- \$1,900 per individual plan;
\$3,800 per family plan in-network
- \$3,800 per individual plan;
\$7,600 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).

- \$2,600 per individual plan;
\$5,200 per family plan in-network
- \$7,800 per individual plan;
\$15,600 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 	0% per visit after deductible	40% per visit after deductible
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) 	0% 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

Beyond Benefits

Sign in to your member page on 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

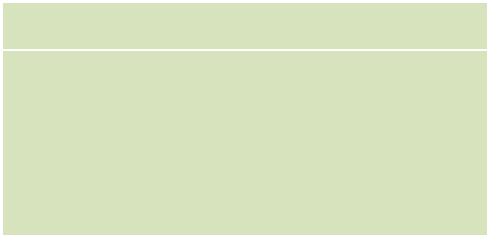
- Locally: (401) 459-5000
- Outside Rhode Island: 1-800-639-2227
- TTY (Telecommunication Device for the Deaf) users should call 711

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
Hospital Emergency Services		0% per visit after deductible	0% per visit after deductible
Urgent Care		0% per visit after deductible	0% per visit after deductible
Telemedicine Visits		0% per visit after deductible	Not covered
Retail-Based Clinic Visits		0% 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 		0% per occurrence after deductible	0% per occurrence after deductible
<ul style="list-style-type: none"> 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		0% per visit after deductible	40% per visit after deductible
<ul style="list-style-type: none"> Physical therapy Occupational therapy Speech therapy 		0% per visit after deductible	40% per visit after deductible
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 		0% per service after deductible	Not covered

*Applicable once deductible is satisfied.



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