

80/60 \$5,900/\$11,800  
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:

- \$5,900 per individual plan;  
\$11,800 per family plan in-network
- \$11,000 per individual plan;  
\$20,800 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).

- \$6,550 per individual plan;  
\$13,100 per family plan in-network
- \$19,950 per individual plan;  
\$39,900 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>	20% 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>	20% 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>	20% 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>	20% 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

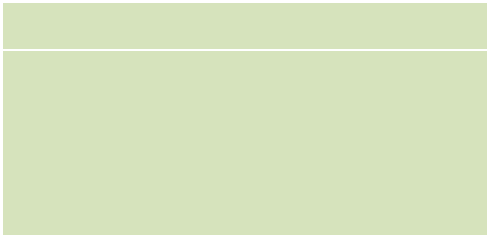
What's covered	What you pay		
	Service	In-Network	Out-of-Network
<b>Hospital Emergency Services</b>		20% per visit after deductible	20% per visit after deductible
<b>Urgent Care</b>		20% per visit after deductible	20% per visit after deductible
<b>Telemedicine Visits</b>		0% per visit after deductible	Not covered
<b>Retail-Based Clinic Visits</b>		20% per visit after deductible	40% per visit after deductible
<b>Ambulance</b>			
▪ Ground		\$50 per occurrence after deductible	\$50 per occurrence after deductible
▪ Air/Water		10% per occurrence after deductible	10% 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>			
▪ Physical therapy		20% per visit after deductible	40% per visit after deductible
▪ Occupational therapy			
▪ Speech therapy			
<b>Prescription Drugs</b>		\$10*-Tier 1; \$50*-Tier 2; \$75*-Tier 3; \$95*-Tier 4; \$150*-Tier 5	Not covered
<b>Pediatric Vision (For dependents under age 19)</b>			
▪ Collection prescription glasses		0% per service after deductible	Not covered
▪ Standard lenses and lens options			
▪ Collection contact lenses			

\*Applicable once deductible is satisfied.



*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.



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