# BlueSolutions

Blue Cross Blue Shield of Rhode Island

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 | What you pay | |
|---|---|---|
| **Service** | **In-Network** | **Out-of-Network** |
| **Preventive Care**<br>▪ Adult preventive care<br>▪ Child preventive care<br>▪ Immunizations<br>▪ Preventive lab, X-ray, and imaging | $0 per visit | 40% per visit after deductible |
| **Primary Care Office Visits**<br>▪ Adult primary care<br>▪ Adult gynecological exam<br>▪ Pediatric primary care | 20% per visit after deductible | 40% per visit after deductible |
| **Specialist Office Visits**<br>▪ Specialty care<br>▪ Chiropractic (limit 20 visits per year)<br>▪ Routine eye exam (limit 1 visit per year) | 20% per visit after deductible | 40% per visit after deductible |
| **Outpatient Services**<br>▪ Diagnostic lab, X-ray, and imaging<br>▪ Medical/surgical care<br>▪ High-end radiology (e.g., MRI/CT/PET), nuclear medicine, and sleep studies | 20% per visit after deductible | 40% per visit after deductible |
| **Inpatient Services**<br>▪ Hospitalization<br>▪ Maternity<br>▪ Mental health<br>▪ Chemical dependency<br>▪ Rehabilitation (limit 45 days per year) | 20% per visit after deductible | 40% per visit after deductible |



**continued**

## 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** | 20% per visit after deductible | 20% per visit after deductible |
| **Urgent Care** | 20% per visit after deductible | 20% 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**<br>▪ Ground | $50 per occurrence after deductible | $50 per occurrence after deductible |
| ▪ Air/Water | 10% per occurrence after deductible | 10% per occurrence after deductible |
| **Durable Medical Equipment** | 20% per service/device after deductible | 40% per service/device after deductible |
| **Physical/Occupational Therapy**<br>▪ Physical therapy<br>▪ Occupational therapy<br>▪ Speech therapy | 20% per visit after deductible | 40% per visit after deductible |
| **Prescription Drugs** | $10*-Tier 1; $50*-Tier 2; $75*-Tier 3; $95*-Tier 4; $150*-Tier 5 | Not covered |
| **Pediatric Vision (For dependents under age 19)**<br>▪ Collection prescription glasses<br>▪ Standard lenses and lens options<br>▪ Collection contact lenses | 0% per service after deductible | Not covered |

*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.*

Blue Cross Blue Shield of Rhode Island
www.bcbsri.com
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.

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|---|---|---|---|
| | Service | In-Network | Out-of-Network |