

## Understanding Your Benefits

### 100/Not covered \$1,500 Coinsurance Plan

#### ■ **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
- Not covered per individual plan;  
Not covered per family plan out-of-network

The deductible has a hybrid calculation, which means that all deductible amounts paid count toward the family deductible, but the individual will never pay more than their individual deductible amount.

#### ■ **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
- Not covered per individual plan;  
Not covered 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.

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	Not covered
<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	Not covered
<b>Specialist Office Visits</b> <ul style="list-style-type: none"> <li>■ Specialty care</li> </ul>	\$30 per visit	Not covered
<b>Chiropractic</b> (limit 20 visits per year)	\$40 per visit	Not covered
<b>Routine eye exam</b> (limit 1 visit per year)	\$0 per visit	Not covered
<b>Outpatient Services</b> <ul style="list-style-type: none"> <li>■ Diagnostic lab</li> <li>■ X-ray and imaging</li> </ul>	\$20 per visit \$50 per visit	Not covered Not covered
<ul style="list-style-type: none"> <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	Not covered

**Please note:**

The deductible and out-of-pocket limits are separate for in-network and out-of-network services.

**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 Service	What You Pay	
	In-Network	Out-of-Network
<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	Not covered
<b>Hospital Emergency Services</b>	\$150 per visit	\$150 per visit
<b>Urgent Care</b>	\$75 per visit	\$75 per visit
<b>Telemedicine Visits</b>	\$20 per visit	Not covered
<b>Retail-Based Clinic Visits</b>	\$25 per visit	Not covered
<b>Ambulance</b> <ul style="list-style-type: none"> <li>Ground</li> <li>Air/Water</li> </ul>	\$50 per occurrence	\$50 per occurrence
<b>Durable Medical Equipment</b>	20% per service/device after deductible	Not covered
<b>Physical/Occupational Therapy</b> <ul style="list-style-type: none"> <li>Physical therapy</li> <li>Occupational therapy</li> <li>Speech therapy</li> </ul>	20% per visit after deductible	Not covered
<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> <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	Not Covered

Members must select a Primary Care Provider (PCP) during enrollment. Failure to select a PCP may result in a reduction in benefits.

This PCP will be the center of the member's care and provide referrals for specialists, tests and other services.



[www.bcbsri.com](http://www.bcbsri.com)

*This is a summary of your Network Blue New England 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.*

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