

100/80 \$250  
Coinsurance Plan

# Understanding Your Benefits

## Deductibles

You pay the following amounts each year before your health plan starts to pay toward the cost of covered services:

- \$250 per individual plan;  
\$500 per family plan in network
- \$1,000 per individual plan;  
\$2,000 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).

- \$750 per individual plan;  
\$1,500 per family plan in network
- \$1,500 per individual plan;  
\$3,000 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 limit.

## 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	20% 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>	\$15 per visit	20% per visit after deductible
<b>Specialist Office Visits</b> <ul style="list-style-type: none"> <li>▪ Specialty care</li> <li>▪ Chiropractic (limit 12 visits per year)</li> <li>▪ Routine eye exam (limit 1 visit per year)</li> </ul>	\$25 per visit	20% per visit after deductible
<b>Outpatient Services</b> <ul style="list-style-type: none"> <li>▪ Diagnostic lab, x-ray, and imaging</li> </ul>	\$0 per visit	20% per visit after deductible
<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	20% 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	20% per visit after deductible
<b>Hospital Emergency Services</b>	\$100 per visit	\$100 per visit
<b>Urgent Care</b>	\$50 per visit	\$50 per visit

### Beyond Benefits

Sign in to your member page on [BCBSRI.com](http://BCBSRI.com), and you will have 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/TDD (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 12 p.m., Eastern Time

What's Covered Service	What You Pay	
	In-Network	Out-of-Network
Telemedicine Visits	\$15 per visit	Not Covered
Retail Based Clinic Visits	\$15 per visit	20% per visit after deductible
Ambulance <ul style="list-style-type: none"> <li>Ground</li> <li>Air/Water</li> </ul>	\$50 per occurrence	\$50 per occurrence
	0% per occurrence after deductible	0% per occurrence after deductible
Durable Medical Equipment	20% per service/device after deductible	20% per service/device after deductible
Physical/Occupational Therapy (limit 30 visits per year) <ul style="list-style-type: none"> <li>Physical therapy</li> <li>Occupational therapy</li> <li>Speech therapy</li> </ul>	20% per visit after deductible	20% per visit after deductible



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

*This is a summary of your HealthMate Coast-to-Coast 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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