

Aides/Monitors - PT3 class 001/1F423 class 001

B.E.S.T. - PT5 class 001/1F425 class 001

Understanding Your Benefits

■ **Deductibles**

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

- \$0 per individual plan; \$0 per family plan in network

- \$100 per individual plan; \$300 per family plan out of network

■ **Out-of-pocket Limits**

To protect you from very high costs, your plan limits how much you could pay out of pocket for healthcare services.

- \$6,350 per individual plan; \$12,700 per family plan in network

- \$6,350 per individual plan; \$12,700 per family plan out of network

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
Preventive Care <ul style="list-style-type: none"> ▪ Adult preventive care ▪ Child preventive care ▪ Immunizations ▪ Preventive and diagnostic lab, X-ray, and imaging 	\$0 per visit in network \$15 plus 20% per visit after deductible out of network
Primary Care Office Visits <ul style="list-style-type: none"> ▪ Adult primary care ▪ Adult gynecological exam ▪ Pediatric primary care 	\$15 per visit in network \$15 plus 20% per visit after deductible out of network
Specialist Office Visits <ul style="list-style-type: none"> ▪ Specialty care ▪ Chiropractic (limit 12 visits per year) ▪ Routine eye exam (limit 1 visit per year) 	\$15 per visit in network \$15 plus 20% per visit after deductible out of network
<ul style="list-style-type: none"> ▪ Allergy and dermatology 	\$20 per visit in network \$20 plus 20% per visit after deductible out of network
Outpatient Services <ul style="list-style-type: none"> ▪ Medical/surgical care ▪ High-end radiology services, major diagnostics, and nuclear medicine (e.g., MRI/CAT/PET) 	\$50 per visit in network \$50 plus 20% per visit out of network 0% per visit in network 20% per visit after deductible out of network
Inpatient Services <ul style="list-style-type: none"> ▪ Acute care ▪ Maternity ▪ Mental health ▪ Chemical dependency ▪ Rehabilitation (limit 45 days per year) 	\$50 per visit in network \$50 plus 20% per visit out of network
Emergency Services <ul style="list-style-type: none"> ▪ Hospital emergency care 	\$100 per visit in network \$100 per visit out of network

What's Covered	What You Pay
Ambulance	\$50 per occurrence in network \$50 per occurrence out of network
Urgent Care Center	\$15 per visit in network \$15 plus 20% per visit after deductible out of network
Durable Medical Equipment	20% per occurrence in network 20% per occurrence after deductible out of network
Physical/Occupational Therapy	
<ul style="list-style-type: none"> ▪ Physical therapy ▪ Occupational therapy ▪ Speech therapy 	20% per visit in network 20% per visit after deductible out of network

Beyond Benefits

When you sign in to your member page on **BCBSRI.com**, you have useful plan and wellness information at your fingertips.

Manage your plan:

- Get a list of your benefits and recent claims.
- See how much you've paid toward your deductible.

Get healthy:

- Read about thousands of health topics in the Health Center.
- Learn how you can get the guaranteed lowest rate on gym memberships, as well as free one-week trial memberships.
- Access our Blue365sm wellness information and discount program.



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., Eastern Time



www.bcbsri.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 our Customer Service Department. If you have questions about receiving medical care, please call your doctor.

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