Effective: 07/01/2017 (Plan Year Deductible)	You Pay	HRA Pays For You	BCBSRI Pays
In-Network Annual Deductible per Individual (Ind)	First $400	Remaining $5,600	100% After Deductible
In-Network Annual Deductible per Family (Fam)	First $700	Remaining $11,300	100% After Deductible
In-Network Coinsurance*	0%	0%*	0%
TIER 1: In-Network Outpatient Preventive and Diagnostic Services			
Preventative Office Visits, Routine GYN, Well Baby Visits	$0	$0	100% Coverage
Preventive Diagnostic X-Rays, Lab Tests, & Imaging	$0	$0	100% Coverage
Adult & Pediatric Preventive Care & Immunizations	$0	$0	100% Coverage
Primary Care Office Visits – up to age 19	$5 Copay	$0	100% after $5 Copay
Primary Care Office Visits – over 19	$5 Copay	$0	100% after $5 Copay
Specialty Care Office Visits	$25 Copay	$0	100% after $25 Copay
Diabetics Foot Exam (limit 1 visit per year)	$0	$0	100% Coverage
Diabetics Eye Exam (limit 1 visit per year)	$0	$0	100% Coverage
Chiropractic Office Visits (Max 12 visits per year)	$25 Copay	$0	100% after $25 Copay
Eye Exams (limit 1 visit per year)	$25 Copay	$0	100% after $25 Copay
Outpatient Mental Health & Substance Abuse treatment	$25 Copay	$0	100% after $25 Copay
Urgent Care (i.e. Walk-in treatment centers)	$75 Copay	$0	100% after $75 Copay
Ambulance Services	$50 Copay	$0	100% after $50 Copay
Emergency Room (Waived if admitted)	$200 Copay	$0	100% after $200 Copay
TIER 1: In-Network Prescription Drug			
Retail Prescription Drugs	$15 / $25 / $40 / $65 Copay + $2 copay for Asthma, Diabetes and COPD drugs	$0	100% after $2 / $15 / $25 / $40 / $65 Copay
TIER 1: In-Network Inpatient Services			
Acute Care	$400 Ind/$700 Fam of Deductible	$5,600 Ind/$11,300 Fam of Deductible	100% After Deductible
Rehabilitation (limit 45 days per year)	$400 Ind/$700 Fam of Deductible	$5,600 Ind/$11,300 Fam of Deductible	100% After Deductible
Maternity-Pre & Post Natal Care	$400 Ind/$700 Fam of Deductible	$5,600 Ind/$11,300 Fam of Deductible	100% After Deductible
Inpatient Mental Health & Substance Abuse	$400 Ind/$700 Fam of Deductible	$5,600 Ind/$11,300 Fam of Deductible	100% After Deductible
TIER 1: In-Network Outpatient Services			
Facility Services	$400 Ind/$700 Fam of Deductible	$5,600 Ind/$11,300 Fam of Deductible	100% After Deductible
Physician/Surgeon Services	$400 Ind/$700 Fam of Deductible	$5,600 Ind/$11,300 Fam of Deductible	100% After Deductible
Diagnostic Labs	$25 Copay	$0	100% after $25 Copay
Diagnostic X-Rays, Imaging and Machine Tests	$50 Copay	$0	100% after $50 Copay
High-end Radiology Services, Major Diagnostics, and Nuclear Medicine	$200 Copay	$0	100% after $200 Copay
Skilled Nursing, Home Health Care, Including Hospice Care	$400 Ind/$700 Fam of Deductible	$5,600 Ind/$11,300 Fam of Deductible	100% After Deductible
Infertility Services & Infertility Oral & Injectable Drugs	$400 Ind/$700 Fam of Deductible	$5,600 Ind/$11,300 Fam of Deductible	100% After Deductible
Short-term Rehabilitation Therapy (Physical, Occupational, & Speech)	$25 Copay	$0	100% after $25 Copay
Durable Medical Equipment	$400 Ind/$700 Fam of Deductible	$5,600 Ind/$11,300 Fam of Ded + 20% after Ded.	80% After Deductible

This benefit description is not a contract or a complete listing of benefits. For more detailed information, please refer to your subscriber agreement and summary of benefit coverage on your secure member home page on BCBSRI.com or call BCBSRI Customer Service.

* Coinsurance may apply to specified services as seen above.

	You Pay	HRA Pays For You	BCBSRI Pays
TIER 2: In-Network Outpatient Preventive and Diagnostic Services			
Preventative Office Visits, Routine GYN, Well Baby Visits	$0	$0	100% Coverage
Preventive Diagnostic X-Rays, Lab Tests, & Imaging	$0	$0	100% Coverage
Adult & Pediatric Preventive Care & Immunizations	$0	$0	100% Coverage
Primary Care Office Visits – up to age 19	$5 Copay	$0	100% after $5 Copay
Primary Care Office Visits – over 19	$25 Copay	$0	100% after $25 Copay
Specialty Care Office Visits	$45 Copay	$0	100% after $45 Copay
Diabetics Foot Exam (limit 1 visit per year)	$0	$0	100% Coverage
Diabetics Eye Exam (limit 1 visit per year)	$0	$0	100% Coverage
Chiropractic Office Visits (Max 12 visits per year)	$45 Copay	$0	100% after $45 Copay
Eye Exams (limit 1 visit per year)	$45 Copay	$0	100% after $45 Copay
Outpatient Mental Health & Substance Abuse treatment	$45 Copay	$0	100% after $45 Copay
Urgent Care (i.e. Walk-in treatment centers)	$75 Copay	$0	100% after $75 Copay
Ambulance Services	$50 Copay	$0	100% after $50 Copay
Emergency Room (Waived if admitted)	$200 Copay	$0	100% after $200 Copay
TIER 2: In-Network Prescription Drug			
Retail Prescription Drugs	$15 / $25 / $40 / $65 Copay + $2 copay for Asthma, Diabetes and COPD drugs	$0	100% after $2 / $15 / $25 / $40 / $65 Copay
TIER 2: In-Network Inpatient Services			
Acute Care	$400 Ind/$700 Fam of Deductible	$5,600 Ind/$11,300 Fam of Ded + 20% after Ded.	80% After Deductible
Rehabilitation (limit 45 days per year)	$400 Ind/$700 Fam of Deductible	$5,600 Ind/$11,300 Fam of Ded + 20% after Ded.	80% After Deductible
Maternity-Pre & Post Natal Care	$400 Ind/$700 Fam of Deductible	$5,600 Ind/$11,300 Fam of Ded + 20% after Ded.	80% After Deductible
Inpatient Mental Health & Substance Abuse	$400 Ind/$700 Fam of Deductible	$5,600 Ind/$11,300 Fam of Deductible	100% After Deductible
TIER 2: In-Network Outpatient Services			
Facility Services	$400 Ind/$700 Fam of Deductible	$5,600 Ind/$11,300 Fam of Deductible	100% After Deductible
Physician/Surgeon Services	$400 Ind/$700 Fam of Deductible	$5,600 Ind/$11,300 Fam of Deductible	100% After Deductible
Diagnostic Labs	$75 Copay	$0	100% after $75 Copay
Diagnostic X-Rays, Imaging and Machine Tests	$150 Copay	$0	100% after $150 Copay
High-end Radiology Services, Major Diagnostics, and Nuclear Medicine	$600 Copay	$0	100% after $600 Copay
Skilled Nursing, Home Health Care, Including Hospice Care	$400 Ind/$700 Fam of Deductible	$5,600 Ind/$11,300 Fam of Deductible	100% After Deductible
Infertility Services & Infertility Oral & Injectable Drugs	$400 Ind/$700 Fam of Deductible	$5,600 Ind/$11,300 Fam of Deductible	100% After Deductible
Short-term Rehabilitation Therapy (Physical, Occupational, & Speech)	$75 Copay	$0	100% after $75 Copay
Durable Medical Equipment	$400 Ind/$700 Fam of Deductible	$5,600 Ind/$11,300 Fam of Ded + 20% after Ded.	80% After Deductible

	You Pay	HRA Pays For You	BCBSRI Pays
Out-Network Annual Deductible per Individual (Ind)	First $200	Remaining Deductible Amounts	50% After Deductible
Out-Network Annual Deductible per Family (Fam)	First $400	Remaining Deductible Amounts	50% After Deductible
Out-Network Coinsurance*	20%	Remaining Coinsurance Amounts	50%
Out-Network Out-of-pocket maximum per Individual	$1,200	N/A	N/A
Out-Network Out-of-pocket maximum per Family	$2,400	N/A	N/A
Out-of-Network Outpatient Preventive and Diagnostic Services			
Preventative Office Visits, Routine GYN, Well Baby Visits	$0	$0	100% Coverage
Preventive Diagnostic X-Rays, Lab Tests, & Imaging	$0	$0	100% Coverage
Adult & Pediatric Preventive Care & Immunizations	$0	$0	100% Coverage
Primary Care Office Visits – up to age 19	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
Primary Care Office Visits – over 19	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
Specialty Care Office Visits	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
Diabetics Foot Exam (limit 1 visit per year)	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
Diabetics Eye Exam (limit 1 visit per year)	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
Chiropractic Office Visits (Max 12 visits per year)	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
Eye Exams (limit 1 visit per year)	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
Outpatient Mental Health & Substance Abuse treatment	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
Urgent Care (i.e. Walk-in treatment centers)	$75 Copay	$0	100% after $75 Copay
Ambulance Services	$50 Copay	$0	100% after $50 Copay
Emergency Room (Waived if admitted)	$200 Copay	$0	100% after $200 Copay
Out-of-Network Prescription Drug			
Retail Prescription Drugs	$15 / $25 / $40 / $65 Copay + $2 copay for Asthma, Diabetes and COPD drugs	$0	100% after $2 / $15 / $25 / $40 / $65 Copay
Out-of-Network Inpatient Services			
Acute Care	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
Rehabilitation (limit 45 days per year)	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
Maternity-Pre & Post Natal Care	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
Inpatient Mental Health & Substance Abuse	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
Out-of-Network Outpatient Services			
Facility Services	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
Physician/Surgeon Services	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
Diagnostic Labs	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
Diagnostic X-Rays, Imaging and Machine Tests	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
High-end Radiology Services, Major Diagnostics, and Nuclear Medicine	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
Skilled Nursing, Home Health Care, Including Hospice Care	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
Infertility Services & Infertility Oral & Injectable Drugs	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
Short-term Rehabilitation Therapy (Physical, Occupational, & Speech)	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible
Durable Medical Equipment	$200 Ind/$400 Fam of Ded + 20% after Ded.	Remaining Deductible and Coinsurance Amounts	50% After Deductible