

# HealthMate Coast-To-Coast



City Non-Union – CPM P1  
 City Non-Bargained – CPM P3  
 PPSP Administrators Non-Union – 5D05 P1  
 PPSP Administrators Non-Bargained – 5D05 P3  
 WSB Non-Union – WSB P1  
 WSB Non-Bargained – WSB P3  
 City Non-Union – RCPM P1  
 City Non-Bargained – RCPM P3  
 WSB Retirees Non-Union – RPWSM P1  
 WSB Retirees Non-Bargained – RPWSM P3

## Understanding Your Benefits

### ■ **Deductibles**

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

- \$200 per individual plan;  
\$600 per family plan in-network\*
- \$200 per individual plan;  
\$600 per family plan out-of-network\*

### ■ **Out-of-pocket Limits**

The following is the maximum you would pay out of pocket for health benefits each year.

- \$2,000 per individual plan;  
\$6,000 per family plan out-of-network

### ■ **Please note:**

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

\*3 family members must meet the individual amount.

| What's Covered   |  | What You Pay                  |  |
|--|--|-------------------------------|--|
| Service  |  | In-Network                    | Out-of-Network                           |
| <b>Preventive Care</b>   |  |                               |  |
| ■ Adult preventive care  |  | \$15 per visit                | \$15 plus 20% per visit                  |
| ■ Child preventive care  |  |                               |  |
| ■ Immunizations  |  | \$0 per visit                 | 20% per visit                            |
| ■ Preventive lab, X-ray, and imaging   |  |                               |  |
| <b>Primary Care Office Visits</b>  |  |                               |  |
| ■ Adult primary care   |  | \$15 per visit                | \$15 plus 20% per visit                  |
| ■ Adult gynecological exam   |  |                               |  |
| ■ Pediatric primary care   |  |                               |  |
| <b>Specialist Office Visits</b>  |  |                               |  |
| ■ Specialty care   |  | \$15 per visit                | \$15 plus 20% per visit after deductible |
| ■ Chiropractic (limit 12 visits per year)                                    |  |                               |  |
| ■ Routine eye exam (limit 1 visit per year)                                  |  | \$10 per visit                | \$10 plus 20% per visit                  |
| <b>Outpatient Services</b>   |  |                               |  |
| ■ Diagnostic lab, X-ray, and imaging   |  | 0% per visit                  | 20% per visit                            |
| ■ Medical/surgical care  |  |                               |  |
| ■ High-end radiology (e.g., MRI/CT/PET), nuclear medicine, and sleep studies |  | 0% per visit after deductible | 20% per visit after deductible           |
| <b>Inpatient Services</b>  |  |                               |  |
| ■ Hospitalization  |  |                               |  |
| ■ Maternity  |  |                               |  |
| ■ Mental health  |  | 0% per visit after deductible | 20% per visit after deductible           |
| ■ Chemical dependency  |  |                               |  |
| ■ Rehabilitation (limit 45 days per year)                                    |  |                               |  |

### 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  | What You Pay   |                         |
|---|--|-------------------------|
| Service   | In-Network   | Out-of-Network          |
| Hospital Emergency Services                                     | \$50 per visit   | \$50 per visit          |
| Urgent Care   | \$15 per visit   | \$15 plus 20% per visit |
| Ambulance   |  |                         |
| ▪ Ground  | \$50 per occurrence  | \$50 per occurrence     |
| ▪ Air/Water   | \$50 per occurrence  | \$50 per occurrence     |
| Durable Medical Equipment                                       | 20% per service/device   | 20% per service/device  |
| Physical/Occupational Therapy                                   |  |                         |
| ▪ Physical therapy  | 20% per visit  | 20% per visit           |
| ▪ Occupational therapy  |  |                         |
| ▪ Speech therapy  |  |                         |
| Vision Hardware   | Age 0-18 up to \$100 per occurrence<br>Age 19 and over \$100 every calendar year<br><i>See Vision Hardware Flyer</i> |                         |
| ▪ Prescription glasses (frames and/or lenses) or contact lenses |  |                         |

*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 benefit booklet 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.*