Bryant University Premium Plan

Blue Cross Blue Shield of Rhode Island

100/80%
No Deductible

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
- $200 per individual plan; $600 per family plan out of network
- Hybrid deductible: All deductible payments count toward the family deductible amount, but the individual will never pay more than their individual deductible amount.

Out-of-pocket Limits

The following is the maximum amount you would pay out-of-pocket for covered healthcare services each year, including deductible, copays, and coinsurance.

- $3,000 per individual plan; $6,000 per family plan in network
- $3,000 per individual plan; $6,000 per family plan out of network
- Hybrid out-of-pocket: All out-of-pocket payments count toward the family out-of-pocket limit. The individual will never pay more than their individual out-of-pocket amount.

Please note:

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

Network:

Extensive national network, with access to thousands of providers across the country.

What's Covered	What You Pay	
Service	In-Network	Out-of-Network
Preventive Care ▪ Adult preventive care ▪ Child preventive care	$0 per visit	$10 plus 20% per visit after deductible
▪ Immunizations ▪ Preventive lab, X-ray, and imaging	$0 per visit	20% per visit after deductible
Primary Care Office Visits ▪ Adult primary care ▪ Adult gynecological exam ▪ Pediatric primary care	$5 per visit PCMH $10 per visit non PCMH	$10 plus 20% per visit after deductible
Specialist Office Visits ▪ Specialty care ▪ Chiropractic (limit 12 visits per year) ▪ Routine eye exam (limit 1 visit per year)	$10 per visit	$10 plus 20% per visit after deductible
Outpatient Services ▪ Diagnostic lab, x-ray, and imaging ▪ Medical/surgical care ▪ Sleep studies	$0 per visit	20% per visit after deductible
▪ High-end radiology (e.g., MRI/CT/PET) and nuclear medicine	$100 per visit in hospital setting $0 per visit in free-standing imaging facility	20% per visit after deductible

continued

Registering Online

- Go to BCBSRI.com
- Click on "Log In to My Account", then click "Register now"
- Follow the registration instructions provided

Access Your Benefits:

- Get a list of your benefits and recent claims.
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Mobile Access:

Your Blue Touch RI – Mobile App

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Your Blue Wire RI – Text Messages

- Members can receive secure personalized messages on their mobile devices, like reminders about flu shots and important tests; money-saving tips; benefit updates, and more.
- Call 1-844-779-8820 to sign up

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	What You Pay	
Service	In-Network	Out-of-Network
Inpatient Services ▪ Hospitalization ▪ Maternity ▪ Mental Health ▪ Chemical Dependency ▪ Rehabilitation (limit 45 days per year)	0% per visit	20% per visit after deductible
Hospital Emergency Services	$50 per visit	$50 per visit
Urgent Care	$10 per visit	$10 plus 20% per visit after deductible
Retail Based Clinic Visits	$10 per visit	$10 plus 20% per visit after deductible
Ambulance ▪ Ground	$50 per occurrence	$50 per occurrence
▪ Air/Water	$50 per occurrence	$50 per occurrence
Durable Medical Equipment ▪ Medical supplies ▪ Diabetic supplies ▪ Prosthetic devices	20% per service/device	20% per service/device after deductible
Physical, Occupational, and Speech Therapy	20% per visit	20% per visit after deductible

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Bryant University Base Plan

Blue Cross Blue Shield of Rhode Island

100/80%
No Deductible

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
- $200 per individual plan; $600 per family plan out of network
- **Hybrid deductible**: All deductible payments count toward the family deductible amount, but the individual will never pay more than their individual deductible amount.

Out-of-pocket Limits

The following is the maximum amount you would pay out-of-pocket for covered healthcare services each year, including deductible, copays, and coinsurance.

- $3,000 per individual plan; $6,000 per family plan in network
- $3,000 per individual plan; $6,000 per family plan out of network
- **Hybrid out-of-pocket**: All out-of-pocket payments count toward the family out-of-pocket limit. The individual will never pay more than their individual out-of-pocket amount.

Please note:

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

Network:

Extensive national network, with access to thousands of providers across the country.

What's Covered	What You Pay	
Service	In-Network	Out-of-Network
Preventive Care ▪ Adult preventive care ▪ Child preventive care	$0 per visit	$15 plus 20% per visit after deductible
▪ Immunizations ▪ Preventive lab, X-ray, and imaging	$0 per visit	20% per visit after deductible
Primary Care Office Visits ▪ Adult primary care ▪ Adult gynecological exam ▪ Pediatric primary care	$10 per visit PCMH $15 per visit non PCMH	$15 plus 20% per visit after deductible
Specialist Office Visits ▪ Specialty care ▪ Chiropractic (limit 12 visits per year) ▪ Routine eye exam (limit 1 visit per year)	$25 per visit	$25 plus 20% per visit after deductible
Outpatient Services ▪ Diagnostic lab, x-ray, and imaging ▪ Medical/surgical care ▪ Sleep studies	$0 per visit	20% per visit after deductible
▪ High-end radiology (e.g., MRI/CT/PET) and nuclear medicine	$100 per visit in hospital setting $0 per visit in free-standing imaging facility	20% per visit after deductible

continued

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What's Covered	What You Pay	
Service	In-Network	Out-of-Network
Inpatient Services ▪ Hospitalization ▪ Maternity ▪ Mental Health ▪ Chemical Dependency ▪ Rehabilitation (limit 45 days per year)	0% per visit	20% per visit after deductible
Hospital Emergency Services	$100 per visit	$100 per visit
Urgent Care	$50 per visit	$50 plus 20% per visit after deductible
Retail Based Clinic Visits	$15 per visit	$15 plus 20% per visit after deductible
Ambulance ▪ Ground	$50 per occurrence	$50 per occurrence
▪ Air/Water	$50 per occurrence	$50 per occurrence
Durable Medical Equipment ▪ Medical supplies ▪ Diabetic supplies ▪ Prosthetic devices	20% per service/device	20% per service/device after deductible
Physical, Occupational, and Speech Therapy	20% per visit	20% per visit after deductible

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Bryant University Value Plan

Blue Cross Blue Shield of Rhode Island

90/70%
No Deductible

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
- $500 per individual plan; $1,000 per family plan out of network
- **Hybrid deductible**: All deductible payments count toward the family deductible amount, but the individual will never pay more than their individual deductible amount.

Out-of-pocket Limits
The following is the maximum amount you would pay out-of-pocket for covered healthcare services each year, including deductible, copays, and coinsurance.

- $3,000 per individual plan; $6,000 per family plan in network
- $5,000 per individual plan; $10,000 per family plan out of network
- **Hybrid out-of-pocket**: All out-of-pocket payments count toward the family out-of-pocket limit. The individual will never pay more than their individual out-of-pocket amount.

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

Network:
Extensive national network, with access to thousands of providers across the country.

What's Covered	What You Pay	
Service	**In-Network**	**Out-of-Network**
Preventive Care ▪ Adult preventive care ▪ Child preventive care	$0 per visit	30% per visit after deductible
▪ Immunizations ▪ Preventive lab, X-ray, and imaging	$0 per visit	30% per visit after deductible
Primary Care Office Visits ▪ Adult primary care ▪ Adult gynecological exam ▪ Pediatric primary care	$20 per visit PCMH $25 per visit non PCMH	30% per visit after deductible
Specialist Office Visits ▪ Specialty care ▪ Chiropractic (limit 12 visits per year) ▪ Routine eye exam (limit 1 visit per year)	$25 per visit	30% per visit after deductible
Outpatient Services ▪ Diagnostic lab, x-ray, and imaging	$0 per visit	30% per visit after deductible
▪ Medical/surgical care	$250 per visit	30% after deductible
▪ High-end radiology (e.g., MRI/CT/PET)	$150 per visit	30% per visit after deductible

continued

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What's Covered	What You Pay	
Service	**In-Network**	**Out-of-Network**
Inpatient Services ▪ Hospitalization ▪ Maternity ▪ Mental Health ▪ Chemical Dependency ▪ Rehabilitation (limit 45 days per year)	$750 per admission	30% per visit after deductible
Hospital Emergency Services	$100 per visit	$100 per visit
Urgent Care	$50 per visit	$50 per visit
Retail Based Clinic Visits	$25 per visit	30% per visit after deductible
Ambulance ▪ Ground	$50 per occurrence	$50 per occurrence
▪ Air/Water	$50 per occurrence	$50 per occurrence
Durable Medical Equipment ▪ Medical supplies ▪ Diabetic supplies ▪ Prosthetic devices	10% per service/device	30% per service/device after deductible
Physical, Occupational, and Speech Therapy	10% per visit	30% per visit after deductible

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Bryant University HDHP Plan with Health Savings Account

Blue Cross Blue Shield of Rhode Island

$1,500/$3,000 High Deductible Health 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:

- $1,500 per individual plan; $3,000 per family plan in network
- $3,000 per individual plan; $6,000 per family plan out of network
- **Aggregate deductible**: All deductible payments count toward the family deductible, one or all can meet it.

Out-of-pocket Limits

The following is the maximum amount you would pay out-of-pocket for covered healthcare services each year, including deductible, copays, and coinsurance.

- $3,000 per individual plan; $6,000 per family plan in network
- $5,000 per individual plan; $10,000 per family plan out of network
- **Aggregate out-of-pocket:** All out-of-pocket payments count toward the family out-of-pocket limit, one or all can meet it.

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Extensive national network, with access to thousands of providers across the country.

What's Covered	What You Pay	
Service	In-Network	Out-of-Network
Preventive Care ▪ Adult preventive care ▪ Child preventive care ▪ Immunizations ▪ Preventive lab, X-ray, and imaging	$0 per visit	20% per visit after deductible
Primary Care Office Visits ▪ Adult primary care ▪ Adult gynecological exam ▪ Pediatric primary care	$15 per visit after deductible PCMH $20 per visit after deductible non-PCMH	20% per visit after deductible
Specialist Office Visits ▪ Specialty care ▪ Chiropractic (limit 12 visits per year) ▪ Routine eye exam (limit 1 visit per year)	$30 per visit after deductible	20% per visit after deductible
Outpatient Services ▪ Diagnostic lab, x-ray, and imaging ▪ 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
Inpatient Services ▪ Hospitalization ▪ Maternity ▪ Mental Health ▪ Chemical dependency ▪ Rehabilitation (limit 45 days per year)	0% per visit after deductible	20% per visit after deductible
Hospital Emergency Services	$100 per visit after deductible	$100 per visit after deductible

continued

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What's Covered	What You Pay	
Service	In-Network	Out-of-Network
Urgent Care	$30 per visit after deductible	$30 per visit after deductible
Retail Based Clinic Visits	$20 per visit after deductible	20% per visit after deductible
Ambulance ▪ Ground	0% per occurrence after deductible	0% per occurrence after deductible
▪ Air/Water	0% per occurrence after deductible	0% per occurrence after deductible
Durable Medical Equipment ▪ Medical supplies ▪ Diabetic supplies ▪ Prosthetic devices	0% per service/device after deductible	20% per service/device after deductible
Physical, Occupational, and Speech Therapy	0% per visit after deductible	20% per visit after deductible
Prescription Drugs	Not Covered	Not Covered

Blue Cross Blue Shield of Rhode Island
www.bcbsri.com

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