

## 100/80 \$2,000 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:

- \$2,000 per individual plan;  
\$4,000 per family plan in-network
- \$4,000 per individual plan;  
\$8,000 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).

- \$3,600 per individual plan;  
\$7,200 per family plan in-network
- \$10,800 per individual plan;  
\$21,600 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<br>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> <small>*1<sup>st</sup> sick visit is free</small> | \$15 per visit for PCMH<br><br>\$25 per visit for non-PCMH | 20% per visit after deductible |
| <b>Specialist Office Visits</b> <ul style="list-style-type: none"> <li>■ Specialty care</li> </ul>  | \$30 per visit   | 20% per visit after deductible |
| <b>Chiropractic</b><br>(limit 20 visits per year)   | \$40 per visit   | 20% per visit after deductible |
| <b>Routine eye exam</b><br>(limit 1 visit per year)   | \$50 per visit   | 20% per visit after deductible |
| <b>Diabetics</b> <ul style="list-style-type: none"> <li>■ Foot exam (limit 1 visit per year)</li> <li>■ Eye exam (limit 1 visit per year)</li> </ul>  | \$0 per visit  | 20% per visit after deductible |
| <b>Outpatient Services</b> <ul style="list-style-type: none"> <li>■ Diagnostic lab</li> </ul>   | \$20 per visit   | 20% per visit after deductible |
| <ul style="list-style-type: none"> <li>■ X-ray, and imaging</li> </ul>  | \$50 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 |

### 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                              |
| <b>Inpatient Services</b> <ul style="list-style-type: none"> <li>Hospitalization</li> <li>Maternity</li> <li>Mental health</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>   | \$150 per visit  | \$150 per visit                         |
| <b>Urgent Care Center</b>  | \$75 per visit   | \$75 per visit                          |
| <b>Telemedicine Visits</b>   | \$25 per visit   | Not Covered                             |
| <b>Retail-Based Clinic Visits</b>  | \$25 per visit   | 20% per visit after deductible          |
| <b>Ambulance</b> <ul style="list-style-type: none"> <li>Ground</li> </ul>  | \$50 per occurrence  | \$50 per occurrence                     |
| <ul style="list-style-type: none"> <li>Air/Water</li> </ul>  | \$50 per occurrence  | \$50 per occurrence                     |
| <b>Durable Medical Equipment</b>   | 20% per service/device after deductible                          | 40% per service/device after deductible |
| <b>Physical/Occupational Therapy</b> <ul style="list-style-type: none"> <li>Physical Therapy</li> <li>Occupational Therapy</li> <li>Speech Therapy</li> </ul>  | 20% per visit after deductible                                   | 40% per visit after deductible          |
| <b>Prescription Drugs</b>  | \$10-Tier 1; \$30-Tier 2; \$50-Tier 3; \$75-Tier 4; \$125-Tier 5 | Not Covered                             |
|  | \$2 for Asthma, Diabetes and COPD                                |   |
| <b>Pediatric Vision (For dependents under age 19)</b> <ul style="list-style-type: none"> <li>Collection prescription glasses</li> <li>Standard lenses and lens options</li> <li>Collection contact lenses</li> </ul> | 0% per service   | Not covered                             |

This is a summary of your VantageBlue 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.