BlueCHiP Advance

Understanding Your Benefits

Tier 1 Deductible: $1,000/$2,000
Tier 2 Deductible: $2,000/$4,000
Copay Plan

- ***Deductibles***
  You pay the following amounts each year before your health plan starts to pay toward the cost of covered services:
  - Tier 1 Deductible – In Network
    - $1,000 per individual plan; $2,000 per family plan
  - Tier 2 Deductible - In Network
    - $2,000 per individual plan; $4,000 per family plan
  - Out of Network Deductible
    - $6,600 per individual plan; $13,200 per family plan out of network
- ***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).
  - $6,800 per individual plan; $13,600 per family plan in network
  - $20,400 per individual plan; $40,800 per family plan out of network

  The deductible and out-of-pocket limits have a hybrid calculation, which means that all deductible amounts paid count toward the family deductible and out-of-pocket limit, but the individual will never pay more than their individual deductible or out-of-pocket amount.

What's Covered	What You Pay			
	In-Network		Out-of-Network	
Service	Tier 1	Tier 2	Tier 1	Tier 2
Preventive Care ▪ Adult preventive care ▪ Child preventive care ▪ Preventive lab, X-ray, & imaging	$0 per visit	$0 per visit	50% per visit after deductible	Not Covered
Primary Care Office Visits ▪ Adult primary care ▪ Adult gynecological exam ▪ Pediatric primary care	$20 per visit	$50 per visit	50% per visit after deductible	Not Covered
Specialist Office Visits ▪ Specialty care ▪ Chiropractic (limit 20 visits per year)	$30 per visit	$60 per visit	50% per visit after deductible	Not Covered
▪ Routine eye exam (limit 1 visit per year)	$45 per visit	$60 per visit	50% per visit after deductible	Not Covered
Outpatient Services ▪ Diagnostic lab	$0 per visit	$25 per visit after deductible	50% per visit after deductible	Not Covered
▪ Diagnostic x-ray and imaging	$0 per visit	$75 per visit after deductible	50% per visit after deductible	Not Covered
▪ Medical/surgical care	$150 per visit after deductible	$1,000 per visit after deductible	50% per visit after deductible	Not Covered
▪ High-end radiology (e.g., MRI/CT/PET), nuclear medicine and sleep studies	$200 per visit after deductible	$600 per visit after deductible	50% per visit after deductible	Not Covered

continued

- ***Please note:***
  The deductible and out-of-pocket limits are separate for in-network and out-of-network services.
- ***Beyond Benefits***
  Sign in to your member page on BCBSRI.com, and you will have 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/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			
	In-Network		Out-of-Network	
Service	Tier 1	Tier 2	Tier 1	Tier 2
Inpatient Services ▪ Hospitalization ▪ Maternity ▪ Rehabilitation (limit 45 days per year)	$500 per admission after deductible	$1,000 per admission after deductible	50% per admission after deductible	Not Covered
▪ Mental health ▪ Chemical dependency	$150 per visit	$150 per visit	50% per visit after deductible	Not Covered
Hospital Emergency Services	$150 per visit	$150 per visit	$150 per visit	$150 per visit
Urgent Care Center	$75 per visit	$75 per visit	$75 per visit	$75 per visit
Telemedicine Visits	$20 per visit	$20 per visit	Not Covered	Not Covered
Retail Based Clinic Visits	$20 per visit	$50 per visit	50% per visit after deductible	Not Covered
Ambulance ▪ Ground ▪ Air/Water (Limit $3,000 per occurrence)	$0 per occurrence	$0 per occurrence	$0 per occurrence	$0 per occurrence
Durable Medical Equipment	30% per service/ device	30% per service/ device	50% per service/ device after deductible	Not Covered
Physical/Occupational Therapy ▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy	$30 per visit	$60 per visit	50% per visit after deductible	Not Covered
Prescription Drugs	$10-Tier 1; $30-Tier 2; $50-Tier 3; $75-Tier 4; $125-Tier 5		Not Covered	
Pediatric Vision ▪ Collection prescription glasses ▪ Standard lenses and lens options ▪ Collection contact lenses	0% per service		Not Covered	

This is a summary of Blue CHiP Advance 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.

www.bcbsri.com

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Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.