

# 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 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 if free</small>	\$20 per visit for PCMH	20% per visit after deductible
	\$30 per visit for Non PCMH	
<b>Specialist Office Visits</b> <ul style="list-style-type: none"> <li>Specialty care</li> </ul>	\$40 per visit	20% per visit after deductible
<b>Chiropractic</b> (limit 20 visits per year)	\$40 per visit	20% per visit after deductible
<b>Routine eye exam</b> (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> <li>X-ray, and imaging</li> </ul>	\$25 per visit	20% per visit after deductible
	\$75 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), 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 Service	What You Pay	
	In-Network	Out-of-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>	\$200 per visit	\$200 per visit
<b>Urgent Care Center</b>	\$100 per visit	\$100 per visit
<b>Telemedicine Visits</b>	\$30 per visit	Not Covered
<b>Retail Based Clinic Visits</b>	\$30 per visit	20% per visit after deductible
<b>Ambulance</b> <ul style="list-style-type: none"> <li>■ Ground</li> <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% after deductible	40% after deductible
<b>Prescription Drugs</b>	\$10-Tier 1; \$40-Tier 2; \$70-Tier 3; \$90-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.*

