VantageBlue

Blue Cross Blue Shield of Rhode Island

100/80 $1,000 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:
  - $1,000 per individual plan; $2,000 per family plan in network
  - $2,000 per individual plan; $4,000 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).
  - $4,000 per individual plan; $8,000 per family plan in network
  - $12,000 per individual plan; $24,000 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	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 *1st sick visit if free	$10 per visit for PCMH $20 per visit for Non PCMH	20% per visit after deductible
Specialist Office Visits ▪ Specialty care	$30 per visit	20% per visit after deductible
Chiropractic (limit 20 visits per year)	$40 per visit	20% per visit after deductible
Routine eye exam (limit 1 visit per year)	$50 per visit	20% per visit after deductible
Diabetics ▪ Foot exam (limit 1 visit per year) ▪ Eye exam (limit 1 visit per year)	$0 per visit	20% per visit after deductible
Outpatient Services ▪ Diagnostic lab	$0 per visit	20% per visit after deductible
▪ X-ray, and imaging	$0 per visit	20% per visit after deductible
▪ 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

continued

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	
Service	**In-Network**	**Out-of-Network**
Inpatient Services ▪ Hospitalization ▪ Maternity ▪ Mental Health ▪ Rehabilitation (limit 45 days per year)	0% per visit after deductible	20% per visit after deductible
Hospital Emergency Services	$100 per visit	$100 per visit
Urgent Care Center	$50 per visit	$100 per visit
Telemedicine Visits	$20 per visit	Not Covered
Retail Based Clinic Visits	$20 per visit	20% per visit after deductible
Ambulance ▪ Ground ▪ Air/Water	$50 per occurrence	$50 per occurrence
Durable Medical Equipment	20% per service/device after deductible	40% per service/device after deductible
Physical/Occupational Therapy ▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy	20% after deductible	40% after deductible
Prescription Drugs	$10-Tier 1; $25-Tier 2; $35-Tier 3; $60-Tier 4; $100-Tier 5 $2 for Asthma, Diabetes and COPD	Not Covered
Pediatric Vision (For dependents under age 19) ▪ Collection prescription glasses ▪ Standard lenses and lens options ▪ Collection contact lenses	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.

Blue Cross Blue Shield of Rhode Island
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