

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).

- \$3,500 per individual plan;
\$7,000 per family plan in-network
- \$10,500 per individual plan;
\$21,000 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	Tier 1 In-Network	Tier 2 In-Network
Preventive Care <ul style="list-style-type: none"> Adult preventive care Child preventive care Preventive lab, X-ray, and imaging 	\$0 per visit	\$0 per visit	50% per visit after deductible
Primary Care Office Visits <ul style="list-style-type: none"> Adult primary care Adult gynecological exam Pediatric primary care *1st visit free 	\$10 per visit	\$30 per visit	50% per visit after deductible
Specialist Office Visits <ul style="list-style-type: none"> Specialty care 	\$30 per visit	\$50 per visit	50% per visit after deductible
<ul style="list-style-type: none"> Chiropractic (limit 20 visits per year) 	\$40 per visit	\$50 per visit	50% per visit after deductible
<ul style="list-style-type: none"> Routine eye exam (limit 1 visit per year) 	\$50 per visit	\$50 per visit	50% per visit after deductible
Diabetics <ul style="list-style-type: none"> Foot exam (limit 1 visit per year) Eye exam (limit 1 visit per year) 	\$0 per visit	\$0 per visit	50% per visit after deductible
Outpatient Services <i>Please note: The Tier 2 copay applies for services provided at hospitals</i> <ul style="list-style-type: none"> Diagnostic lab 	\$25 per visit	\$75 per visit	50% per visit after deductible
<ul style="list-style-type: none"> Diagnostic X-ray and imaging 	\$50 per visit	\$150 per visit	50% per visit after deductible

Beyond Benefits

Sign in to your member page on 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

Service	What you pay		
	Tier 1 In-Network	Tier 2 In-Network	Out-of-Network
<ul style="list-style-type: none"> High-end radiology (e.g., MRI/CT/PET), nuclear medicine, and sleep studies 	\$200 per visit	\$600 per visit	50% per visit after deductible
<ul style="list-style-type: none"> Medical/surgical care 	0% per visit after deductible	0% per visit after deductible	50% per visit after deductible
Inpatient Services			
<ul style="list-style-type: none"> Hospitalization Maternity Rehabilitation (limit 45 days per year) 	0% per visit after deductible	20% per visit after deductible	50% per visit after deductible
<ul style="list-style-type: none"> Mental health Chemical dependency 	0% per visit after deductible	0% per visit after deductible	50% per visit after deductible
Hospital Emergency Services	\$200 per visit	\$200 per visit	\$200 per visit
Urgent Care Center	\$100 per visit	\$100 per visit	\$100 per visit
Telemedicine Visits	\$10 per visit	\$10 per visit	Not covered
Retail-Based Clinic Visits	\$30 per visit	\$30 per visit	50% per visit after deductible
Ambulance			
<ul style="list-style-type: none"> Ground 	\$50 per occurrence	\$50 per occurrence	\$50 per occurrence
<ul style="list-style-type: none"> Air/Water 	\$50 per occurrence	\$50 per occurrence	\$50 per occurrence
Durable Medical Equipment	20% per service/device after deductible	20% per service/device after deductible	50% per service/device after deductible
Physical/Occupational Therapy			
<ul style="list-style-type: none"> Physical Therapy Occupational Therapy Speech Therapy 	\$25 per visit	\$75 per visit	50% per visit after deductible
Prescription Drugs	\$10-Tier 1; \$30-Tier 2; \$50-Tier 3; \$75-Tier 4; \$125-Tier 5 \$2 for Asthma, Diabetes and COPD		Not covered

This is a summary of VantageBlue SelectRI 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.



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

What's covered	What you pay		
Service	Tier 1 In-Network	Tier 2 In-Network	Out-of- Network
Pediatric Vision (for dependents under age 19) <ul style="list-style-type: none"> ▪ Collection prescription glasses ▪ Standard lenses and lens options ▪ Collection contact lenses 	0% per services	0% per service	Not covered