At a glance: Your health plan choices

All of our plans include the following benefits:

- 100% coverage for many in-network preventive services (e.g., annual physical)
- Wellness program and incentives (up to $250)
- Full coverage for education programs on smoking cessation, asthma, and diabetes
- 20% discount on CVS Pharmacy® brand health-related items with the ExtraCare® Health card

See the chart below for features and highlights across our portfolio of plans:

	BlueCHiP	BlueSolutions for HSA	BasicBlue	VantageBlue
Lower premiums	✓		✓	
Type of network	Local	National	National	National
Out-of-network coverage	Not covered	Not covered	Not covered	Not covered
Incentives	Up to a $250 reward (applies to subscriber and covered spouse)			
Referral required	✓			
Tax savings opportunities		✓		
Pre-deductible coverage for most office visits	✓		✓	✓
$2 copays for certain maintenance drugs to treat diabetes, asthma, and COPD				✓

Gold-Level Health Plans	VantageBlue Direct 1325/2650	VantageBlue Direct 3250/6500	BlueSolutions for HSA Direct 1400/2800	BasicBlue Direct 2750/5500	BlueCHiP Direct 2300/4600
	You pay	You pay	You pay	You pay	You pay
In-network deductible	$1,325 individual - $2,650 family	$3,250 individual - $6,500 family	$1,400 individual - $2,800 family	$2,750 individual - $5,500 family	$2,300 individual - $4,600 family
In-network out-of-pocket maximum (OOP)	$4,225 individual - $8,450 family	$6,825 individual - $13,650 family	$3,500 individual - $7,000 family	$2,750 individual - $5,500 family	$3,900 individual - $7,800 family
Coinsurance	20% after deductible	20% after deductible	0% after deductible	0% after deductible	10% after deductible
Preventive services (annual exam)	$0	$0	$0	$0	$0
Primary care provider (PCP) office visit when PCP is part of a patient-centered medical home	$20 (first sick visit free)	$30 (first sick visit free)	$15 after deductible	$15	$15
Primary care provider (PCP) office visit when PCP is *NOT* part of a patient-centered medical home	$30	$40	$35 after deductible	$25	$35
Telemedicine	$30	$40	$0 after deductible	$25	$35
Retail clinic	$45	$45	$40 after deductible	$30	$45
Specialist visit	$45	$45	$40 after deductible	$30	$45
Annual foot and eye exam for members with diabetes	$0	$0	$40 after deductible	$30	$45
Urgent care center	$75	$75	$75 after deductible	$0 after deductible	$75
Emergency room	$200	$200	$150 after deductible	$0 after deductible	10% after deductible
Inpatient hospital	20% after deductible	20% after deductible	$200 per admission after deductible	$0 after deductible	10% after deductible
Diagnostic laboratory tests	20% after deductible	20% after deductible	$0 after deductible	$0 after deductible	10% after deductible
X-rays	20% after deductible	20% after deductible	$0 after deductible	$0 after deductible	10% after deductible
High-end radiology *(i.e., MRI, PET, and CAT scan, etc.)*	20% after deductible	20% after deductible	$150 after deductible	$0 after deductible	10% after deductible
Prescriptions					
Tier 1	$10	$10	$10 after deductible	$10	$10
Tier 2	$25	$30	$25 after deductible	$30	$25
Tier 3	$50	$60	$50 after deductible	$0 after deductible	$50 after deductible
Tier 4	$75	$80	$75 after deductible	$0 after deductible	$75 after deductible
Tier 5	$125	$125	$125 after deductible	$0 after deductible	$125 after deductible

This is a summary of benefits. It is not a contract. For details about coverage, including any limits and exclusions not noted here, please call our Sales Department at 1-855-690-2583 or refer to the health plan's subscriber agreement at bcbsri.com/shop-for-plan/2018.

Silver-Level Health Plans	BasicBlue Direct 4900/9800	VantageBlue Direct 4850/9700	BlueSolutions for HSA Direct 4100/8200	BlueCHiP Direct 4800/9600
	You pay	You pay	You pay	You pay
In-network deductible	$4,900 individual - $9,800 family	$4,850 individual - $9,700 family	$4,100 individual - $8,200 family	$4,800 individual - $9,600 family
In-network out-of-pocket maximum (OOP)	$5,500 individual - $11,000 family	$7,225 individual - $14,450 family	$4,600 individual - $9,200 family	$5,800 individual -$11,600 family
Coinsurance	10% after deductible	30% after deductible	20% after deductible	10% after deductible
Preventive services (annual exam)	$0	$0	$0	$0
Primary care provider (PCP) office visit when PCP is part of a patient-centered medical home	$10	$40 (first sick visit free)	20% after deductible	$25
Primary care provider (PCP) office visit when PCP is *NOT* part of a patient-centered medical home	$20	$60	20% after deductible	$45
Telemedicine	$20	$40	20% after deductible	$40
Retail clinic	$45	$50	20% after deductible	$50
Specialist visit	$45	$65	20% after deductible	$60
Annual foot and eye exam for members with diabetes	$45	$0	20% after deductible	$60
Urgent care center	$75 after deductible	$75	20% after deductible	$75
Emergency room	10% after deductible	$275	20% after deductible	10% after deductible
Inpatient hospital	10% after deductible	30% after deductible	20% after deductible	10% after deductible
Diagnostic laboratory tests	10% after deductible	30% after deductible	20% after deductible	10% after deductible
X-rays	10% after deductible	30% after deductible	20% after deductible	10% after deductible
High-end radiology *(i.e. MRI, PET, and CAT scan, etc.)*	10% after deductible	30% after deductible	20% after deductible	10% after deductible
Prescriptions				
Tier 1	$10	$10	$10 after deductible	$7
Tier 2	$30	$35	$30 after deductible	$35
Tier 3	$50 after deductible	$80	$50 after deductible	$50 after deductible
Tier 4	$75 after deductible	$100	$75 after deductible	$75 after deductible
Tier 5	$100 after deductible	$250	$100 after deductible	$100 after deductible

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Bronze-Level Health Plans	BlueSolutions for HSA Direct 6000/12000	BasicBlue Direct 6850/13700
	You pay	You pay
In-network deductible	$6,000 individual - $12,000 family	$6,850 individual - $13,700 family
In-network out-of-pocket maximum (OOP)	$6,550 individual - $13,100 family	$6,850 individual - $13,700 family
Coinsurance	0% after deductible	0% after deductible
Preventive services (annual exam)	$0	$0
Primary care provider (PCP) office visit when PCP is part of a patient-centered medical home	$0 after deductible	$30
Primary care provider (PCP) office visit when PCP is *NOT* part of a patient-centered medical home	$0 after deductible	$50
Telemedicine	$0 after deductible	$40
Retail clinic	$0 after deductible	$50
Specialist visit	$0 after deductible	$60
Annual foot and eye exam for members with diabetes	$0 after deductible	$60
Urgent care center	$0 after deductible	$0 after deductible
Emergency room	$0 after deductible	$0 after deductible
Inpatient hospital	$0 after deductible	$0 after deductible
Diagnostic laboratory tests	$0 after deductible	$0 after deductible
X-rays	$0 after deductible	$0 after deductible
High-end radiology *(i.e., MRI, PET, and CAT scan, etc.)*	$0 after deductible	$0 after deductible
Prescriptions		
Tier 1	$10 after deductible	$10
Tier 2	$35 after deductible	$50
Tier 3	$60 after deductible	$0 after deductible
Tier 4	$100 after deductible	$0 after deductible
Tier 5	$200 after deductible	$0 after deductible

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Blue Cross Dental

All our plans cover you in- and out-of-network coast-to-coast and include pediatric dental benefits.

Benefits (over age 19)	Direct Basic	Direct Standard	Direct Plus	Direct Elite
Calendar year maximum	$1,000	$1,000	$1,500	$2,000
Dependent coverage up to age	26	26	26	26
	You pay	**You pay**	**You pay**	**You pay**
Deductible	$0	$0	$0	$50
Diagnostic and preventive services				
Cleanings, oral exam, bitewing X-rays, complete X-ray series, and single X-rays	0%	0%	0%	0%
Palliative treatment (minor treatment to relieve acute pain)	50%	40%	0%	0%
Basic services				
Fillings	50%	40%	20%	20% after deductible
Simple extractions	Not covered	40%	20%	20% after deductible
Denture repairs, adjustments, relines, and rebasing	Not covered	50%*	50%*	20% after deductible*
Root canal therapy	Not covered	40%**	50%**	20% after deductible**
Non-surgical periodontics	Not covered	Not covered	50%**	20% after deductible**
Surgical periodontics	Not covered	Not covered	50%**	50% after deductible**
Oral surgery and general anesthesia	Not covered	40%**	50%**	20% after deductible**
Major services				
Crowns and onlays	Not covered	Not covered	50%**	50% after deductible**
Fixed bridges, partial and complete dentures, and single tooth implant	Not covered	Not covered	50%**	50% after deductible**
Oral appliances				
Night guards	50%	50%	50%	50%

All plans are Qualified Dental Plans that meet the ACA guidelines for pediatric dental coverage. Please see next page for more information.
** 6-month waiting period applies, which means that these services are available once your policy has been in effect for 6 continuous months.*
*** 12-month waiting period applies, which means that these services are available once your policy has been in effect for 12 continuous months. We will accept evidence of substantially similar prior coverage to meet the waiting period requirements.*
This is a summary of benefits. It is not a contract. For details about coverage, including any limits and exclusions not noted here, please call our Sales Department at 1-855-690-2583 or refer to the dental plan's subscriber agreement online at ***bcbsri.com/dental****.*

Over half of American children will be affected by tooth decay before age 5.

And children lose 52 million school hours per year due to dental problems. To keep their teeth healthy, your child should visit the dentist for a cleaning TWO times a year, and they should brush and floss ***TWO times a day for TWO whole minutes!***

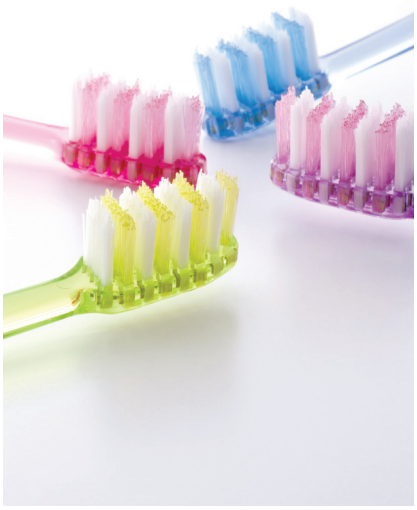
Source: American Academy of Pediatric Dentistry

Brush TWO minutes

twice a day for healthy teeth

PEDIATRIC DENTAL BENEFITS (UP TO AGE 19)

Benefits	Direct Basic & Direct Standard	Direct Plus & Direct Elite
	You pay	
In-network out-of-pocket maximum	$350 individual/$700 family	
Deductible	$150 per person	$25 per person
Cleanings*, oral exams, X-rays, fluoride treatments, space maintainers, and sealants	0%	
Palliative treatment (minor treatment to relieve acute pain)	20%	
Fillings	50% after deductible	
Simple extractions, partial/denture repairs, relines and rebasing, periodontal treatments, root canals, oral surgery, crowns and prosthodontics	75% after deductible	50% after deductible
Orthodontics (medically necessary only)	50% after deductible	
Night guards	50%	
No waiting period for pediatric dental benefits. ** Cleanings: Direct Basic & Direct Standard - 2/year, Direct Plus & Direct Elite - 3/year*		



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BLUE CROSS DENTAL DIRECT MONTHLY RATES

Rates are determined per individual. The premium rate for family coverage is based on the number of individuals in the family that enroll in coverage and the age of each family member. If you have children and they are covered under the plan, you will only pay premium for the three oldest children under the age of 21.

Age	Direct Basic	Direct Standard	Direct Plus	Direct Elite
0-18	$20.53	$20.53	$35.51	$35.51
19-29	$17.12	$22.85	$35.40	$49.06
30-39	$17.12	$22.85	$35.40	$49.06
40-49	$17.12	$22.85	$35.40	$49.06
50-59	$18.83	$25.13	$38.94	$53.97
60 +	$21.40	$28.56	$44.25	$61.32