VantageBlue SELECTRI | Blue Cross Blue Shield of Rhode Island

80/60/40 3000 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:

- $3,000 per individual plan; $6,000 per family plan in network
- $6,000 per individual plan; $12,000 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).

- $6,350 per individual plan; $12,700 per family plan in network
- $9,600 per individual plan; $19,200 per family plan out of network

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**	**Out of Network**
Preventive Care ▪ Adult preventive care ▪ Child preventive care ▪ Immunizations ▪ Preventive lab, X-ray, and imaging	$0	$0	60% per visit after deductible
Primary Care Office Visits ▪ Adult primary care ▪ Adult gynecological exam ▪ Pediatric primary care	$10 per visit	$10 per visit up to age 19 $30 per visit over age 19	60% per visit after deductible
Specialist Office Visits ▪ Specialty care ▪ Chiropractic (limit 20 visits per year) ▪ Routine eye exam (limit 1 visit per year)	$30 per visit	$50 per visit	60% per visit after deductible
Diabetics ▪ Foot Exam (limit 1 visit per year) ▪ Eye Exam (limit 1 visit per year)	$0 per visit	$0 per visit	60% per visit after deductible
Outpatient Services ***Please note:*** *The tier 2 copay applies for services provided at hospitals* ▪ Diagnostic lab	$25 per visit	$75 per visit	60% per visit after deductible
▪ Diagnostic x-ray and imaging	$50 per visit	$150 per visit	60% per visit after deductible
▪ High-end radiology (e.g., MRI/CT/PER), nuclear medicine and sleep studies	$200 per visit	$600 per visit	60% per visit after deductible
▪ Medical/surgical care	20% per visit after deductible	20% per visit after deductible	60% 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 and 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.
- Access our Blue365℠ wellness information and discount program.

Diminishing Deductible:

Here's how it works: When your annual medical expenses fall below your plan's individual or family deductible, your deductible is reduced by a percentage the next year. Over time, your deductible could be reduced by up to 50 percent.

Need help?

Call Customer Service at the number located on the back of your BCBSRI ID card.

What's Covered	What You Pay		
Service	**Tier 1 In Network***	**Tier 2 In Network**	**Out of Network**
Inpatient Services ▪ Hospitalization ▪ Maternity ▪ Rehabilitation (limit 45 days per year)	20% per visit after deductible	40% per visit after deductible	60% per visit after deductible
▪ Mental Health ▪ Chemical dependency	20% per visit after deductible	20% per visit after deductible	60% per visit after deductible
Hospital Emergency Services	$200 per visit	$200 per visit	$200 per visit
Urgent Care Center	$75 per visit	$75 per visit	$75 per visit
Ambulance ▪ Ground	$50 per occurrence	$50 per occurrence	$50 per occurrence
▪ 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	60% per service/device after deductible
Physical/Occupational Therapy ▪ Physical therapy ▪ Occupational therapy ▪ Speech therapy	$25 per visit	$75 per visit	60% per visit after deductible
Prescription Drugs	$5-Tier 1; $18-Tier 2; $40-Tier 3; $80-Tier 4; $200-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	$0 per service	Not covered
Pediatric Dental (for dependents under age 19) ▪ Oral exams, cleanings, X-rays (bitewing, panoramic and individual), fluoride treatments and sealants	0% per visit	0% per visit	0% per visit
▪ All other covered dental services	50% per visit	50% per visit	50% per visit

***Tier 1 In Network** providers are easy to find. Go to **BCBSRI.com**.

Blue Cross Blue Shield of Rhode Island

www.bcbsri.com

This is a summary of your VantageBlue SelectRI Direct 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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