

What Your Health Plan Covers



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

Out-of-pocket Limits

To protect you from very high costs, your plan limits how much you could pay out of pocket for healthcare services. The following is the most you would pay for deductibles and coinsurance each year:

- \$6,000 per individual plan/\$12,000 per family plan in network
- \$12,000 per individual plan/\$24,000 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
Preventive Care <ul style="list-style-type: none"> • Adult preventive care • Child preventive care • Immunizations • Lab services 	\$0 in network 20% after deductible out of network
Primary Care Office Visits <ul style="list-style-type: none"> • Adult primary care • Adult gynecological exam • Pediatric primary care 	\$15 per visit in network 20% per visit after deductible out of network
Specialist Office Visits <ul style="list-style-type: none"> • Specialty care • Chiropractic (limit 12 visits/year) • Routine eye exam (limit 1/year) 	\$30 per visit in network 20% per visit after deductible out of network
Outpatient Services <ul style="list-style-type: none"> • Medical/surgical care • Lab & X-ray services 	0% after deductible in network 20% after deductible out of network
Inpatient Services <ul style="list-style-type: none"> • Acute care • Maternity • Mental health • Chemical dependency • Rehabilitation (limit 45 days/year) 	0% after deductible in network 20% after deductible out of network
Emergency Services <ul style="list-style-type: none"> • Hospital emergency care 	\$100 per visit in network \$100 per visit out of network

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What's Covered	What You Pay
Ambulance	\$50 per occurrence in network \$50 per occurrence out of network
Urgent Care Center	\$50 per visit in network \$50 per visit out of network
Durable Medical Equipment	20% after deductible in network 20% after deductible out of network
Physical/Occupational Therapy <ul style="list-style-type: none"> • Physical therapy • Occupational therapy • Speech therapy 	20% after deductible in network 20% after deductible out of network
Prescription Drugs	\$10 Tier 1; \$35 Tier 2; \$60 Tier 3; \$100 Tier 4

Beyond Benefits

When you sign in to your Member page on BCBSRI.com, you have useful plan and wellness information at your fingertips.

Manage your plan:

- Get a list of your benefits and recent claims.
- See how much you've paid toward your deductible.

Get healthy:

- Read about thousands of health topics in the Health Center.
- Learn how you can get the guaranteed lowest rate on gym memberships, as well as free one-week trial memberships.
- Access our Blue365 wellness information and discount program.

Need help?

Call Customer Service:

- Locally: (401) 459-5000
- Outside Rhode Island: 1-800-639-2227
- TDD: 1-888-252-5051

Hours: Monday – Friday, 8:00 a.m. to 8:00 p.m.

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 our Customer Service Department. If you have questions about receiving medical care, please call your doctor.



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