# 12 Insurance Plans Are Available to Meet the Needs of Individuals and their Families

HealthSourceRI
YOUR HEALTH. YOUR WAY.

## Individual Premiums

These premiums do not factor in tax credits and other cost-sharing assistance that many Rhode Islanders may qualify for.
Those with incomes below 400% of the Federal Poverty Level (which is $45,960 for individuals and $94,200 for a family of four) may qualify for tax creditsto make their monthly insurance premiums more affordable.
Tax credit calculators will be available on HealthSourceRI.com to help individuals, families and small employers.

| Insurance Company | BCBSRI | BCBSRI | BCBSRI | NHPRI* | BCBSRI | BCBSRI | BCBSRI | NHPRI* | BCBSRI | BCBSRI | BCBSRI | BCBSRI |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Plan Name** | BlueSolutions for HSA Direct 1500/3000 | VantageBlue Direct Plan 1000/2000 | VantageBlue SelectRI Direct 500/1000 | Neighborhood Health Plan of RI Plus | BlueSolutions for HSA Direct 2600/5200 | VantageBlue Direct 3000/6000 | VantageBlue SelectRI Direct 3000/6000 | Neighborhood Health Plan of RI Value | BlueSolutions for HSA Direct 5000/10000 | Vantage Blue Direct 5800/11600 | VantageBlue SelectRI Direct 5800/11600 | BasicBlue Direct |
| **Federal Plan Categories** | Gold | Gold | Gold | Gold | Silver | Silver | Silver | Silver | Bronze | Bronze | Bronze | Catastrophic Plan*** |
| **Monthly Premium** (Rate for 21-year-old) | $261 | $276 | $282 | $269 | $214 | $230 | $235 | $232 | $166 | $169 | $177 | $150 |
| **Monthly Premium** (Rate for 45-year-old) | $377 | $399 | $408 | $389 | $310 | $332 | $339 | $335 | $240 | $244 | $255 | N/A*** |

## How You Get Your Care = The Provider Network

Some plans have established a tiered value system for their providers (such as doctors and hospitals).

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Network Type** | Preferred Provider Organization (PPO) | Preferred Provider Organization (PPO) | Preferred Provider Organization (PPO) with Tiers | Health Maintenance Organization (HMO) | Preferred Provider Organization (PPO) | Preferred Provider Organization (PPO) | Preferred Provider Organization (PPO) with Tiers | Health Maintenance Organization (HMO) | Preferred Provider Organization (PPO) | Preferred Provider Organization (PPO) | Preferred Provider Organization (PPO) with Tiers | Preferred Provider Organization (PPO) |
| **Other Features** | HSA Qualified | | | | HSA Qualified | | | | HSA Qualified | | | Catastrophic Plan |

## Services

All plans must cover the same set of services.

SERVICES MUST INCLUDE: Ambulatory patient services (outpatient care you get without being admitted to a hospital), emergency services, hospitalization, maternity and newborn care, mental health and substance use treatment services (this includes counseling and psychotherapy), prescription drugs, rehabilitative and habilitative services and devices, lab services, preventive and wellness services, chronic disease management, and pediatric services.

## Preventive Services and Screenings

All plans must cover the same set of preventive services.

PREVENTIVE SERVICES INCLUDE: Blood pressure screening, breast cancer screening and mammography, cervical cancer screening (Pap test) cholesterol screening, colorectal cancer screening, contraceptive services, depression screening, hypertension screening, obesity screening and counseling. Adult immunizations such as flu shots, Hepatitis A and B, and pneumonia shots will also be covered.

## Deductibles**

A type of cost-sharing that requires you to pay a specific amount of money for certain health care services before your plan will begin to pay the remainder.
This amount is in addition to the monthly premium.

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| **Deductible - Medical** | $1,500 Individual $3,000 Family | $1,000 Individual $2,000 Family | $500 Individual $1,000 Family | $2,000 Individual $4,000 Family | $2,600 Individual $5,200 Family | $3,000 Individual $6,000 Family | $3,000 Individual $6,000 Family | $3,000 Individual $6,000 Family | $5,000 Individual $10,000 Family | $5,800 Individual $11,600 Family | $5,800 Individual $11,600 Family | $6,350 Individual $12,700 Family |
| **Deductible - Drug** | Combined with medical | $0 Drug | $0 Drug | $100 Individual /$200 Family | Combined with medical | $0 Drug | $0 Drug | $250 Individual / $500 Family | Combined with medical | $500 Drug | $500 Drug | Combined with medical |

## Coinsurance & Copayments**

**Coinsurance:** A type of cost-sharing that requires you to pay a percentage of the cost for certain types of health care services usually once you have met the deductible.
**Copayments:** A type of cost-sharing that requires you to pay a fixed dollar amount for certain types of health care services each time you use them.
In some plans payments reflect a tiered value system for their providers (such as doctors and hospitals).

***The WHITE area is not subject to the deductible. It is the dollar amount or percentage you pay per visit or health care service regardless of whether you have met your deductible.***

***The SHADED area is subject to the deductible. You pay the full cost of a visit or health care service until you reach your deductible. After that you only pay the dollar amount or percentage shown.***

***PCMH = Primary Care Medical Home, also referred to as Patient Centered Medical Home, is a team of providers that may include physicians, nurses, pharmacists, nutritionists, social workers, educators and care coordinators.***

***PCP = Primary Care Physician***

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| **ER Services** | 0% | $200 | $200 | $100 | 10% | $200 | $200 | $200 | 0% | $350 | $350 | 0% |
| **Inpatient Hospital** | 0% | 20% | 20% Tier 1 40%Tier 2 | 20% | 10% | 20% | 20% Tier 1 40%Tier 2 | 30% | 0% | 30% | 30% Tier 1 50%Tier 2 | 0% |
| **Primary Care** | 0% | $15 per visit to a PCMH or you are under age 19; $25 per visit to a non-PCMH | $10 Tier 1 PCP (including those under 19); $30 Tier 2 PCP | $10 | 10% | $15 per visit to a PCMH (or you are under age 19; $25 per visit to a non-PCMH | $10 Tier 1 PCP (including those under 19); $30 Tier 2 PCP | $25 | 0% | $40 per visit to a PCMH; $60 per visit to a PCP | $40 Tier 1 PCP/ PCMH; $60 Tier 2 PCP | $25 for first 3 office visits; 100% coverage after deductible for all subsequent visits |
| **Specialist Visit** | 0% | $40 | $30 Tier 1 $50 Tier 2 | $20 | 10% | $40 | $30 Tier 1 $50 Tier 2 | $50 | 0% | $75 | $65 Tier 1 $85 Tier 2 | |
| **Mental Health and Substance Abuse - Office Visits** | 0% | $40 | $30 Tier 1 $50 Tier 2 | $10 | 10% | $40 | $30 Tier 1 $50 Tier 2 | $25 | 0% | $75 | $65 Tier 1 $85 Tier 2 | 0% |
| **High End Imaging: CT/PET/MRI** | 0% | 20% | $200 Tier 1 $600 Tier 2 | 20% | 10% | 20% | $200 Tier 1 $600 Tier 2 | 30% | 0% | 30% | $200 Tier 1 $600 Tier 2 | 0% |
| **Speech/Occup/ Phys Therapy** | 0% | 20% | $25 Tier 1 $75 Tier 2 | $20 | 10% | 20% | $25 Tier 1 $75 Tier 2 | $50 | 0% | 30% | $25 Tier 1 $75 Tier 2 | 0% |
| **Preventive Care** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Lab Services, Outpatient** | 0% | 20% | $25 Tier 1 $75 Tier 2 | 20% | 10% | 20% | $25 Tier 1 $75 Tier 2 | 30% | 0% | 30% | $25 Tier 1 $75 Tier 2 | 0% |
| **X-rays and Other Diag. Imaging** | 0% | 20% | $50 Tier 1 $150 Tier 2 | 20% | 10% | 20% | $50 Tier 1 $150 Tier 2 | 30% | 0% | 30% | $50 Tier 1 $150 Tier 2 | 0% |
| **Skilled Nursing Facility** | 0% | 20% | 20% | 20% | 10% | 20% | 20% | 30% | 0% | 30% | 30% | 0% |
| **Outpatient Facility Fee** | 0% | 20% | 20% | 20% | 10% | 20% | 20% | 30% | 0% | 30% | 30% | 0% |
| **Outpatient Surgery/Services** | 0% | 20% | 20% | 20% | 10% | 20% | 20% | 30% | 0% | 30% | 30% | 0% |
| **Prescription Drugs:** | | | | | | | | | | | | |
| ***Tier 1*** | 3 | $3 | $3 | $5 | 3 | $5 | $5 | $10 | 3 | $13 | $13 | 0% |
| ***Tier 2*** | $12 | $12 | $12 | $20 after Rx ded. | $12 | $18 | $18 | $40 after Rx ded. | $12 | $35 | $35 | 0% |
| ***Tier 3*** | $35 | $35 | $35 | $40 after Rx ded. | $35 | $40 | $40 | $60 after Rx ded. | $35 | 50% after Rx ded. | 50% after Rx ded. | 0% |
| ***Tier 4*** | $60 / $100 | $60 / $100 | $60 / $100 | $40 after Rx ded. | $60 / $100 | $90 / $200 | $90 / $200 | $60 after Rx ded. | $60 / $100 | 50% / $250 after Rx ded. | 50% / $250 after Rx ded. | 0% |

## Maximum Out-of-Pocket**

The maximum amount of money you will pay for health care services in a given year (in addition to your monthly premium). This includes your deductible, copayments and coinsurance.

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Maximum Out of Pocket (MOOP) Medical** | $2,250 Individual $4,500 Family | $4,000 Individual $8,000 Family | $4,000 Individual $8,000 Family | $4,000 Individual $8,000 Family | $4,000 Individual $8,000 Family | $6,350 Individual $12,700 Family | $6,350 Individual $12,700 Family | $5,000 Individual $10,000 Family | $6,350 Individual $12,700 Family | $6,350 Individual $12,700 Family | $6,350 Individual $12,700 Family | $6,350 Individual $12,700 Family |
| **Maximum Out of Pocket (MOOP) Drug** | | | | $500 Individual $1,000 Family | | | | $1,000 Individual $2,000 Family | | | | |

* These plans are available to individuals with incomes below $28,725 or families of four with incomes below $58,875.

**You may pay less if you are an individual with an annual income below $28,725 or a family of four with an annual income below $58,875

***Catastrophic plans are only available to those under 30 years of age unless your plan is deemed unaffordable. PPACA Sec. 1302(e)(2); 45 CFR 156.155

*This is a partial summary of benefits and coverage and should not be considered a contract. This information, including all quoted rates, should be used for informational purposes only. Changes may be made to the benefits and coverage policies described here. You should only rely upon the Evidence of Coverage document provided to you from your health insurance company for information on rates, covered benefits, limitations and exclusions.*