Network Blue NE Options $5,000 Deductible

Blue Cross Blue Shield of Rhode Island

Understanding Your Benefits

Registering Online at myBCBSRI

- Go to **myBCBSRI.com**
- Click on "Register Here"
- Follow the registration instructions provided

Deductibles

- **$5,000** per individual plan; **$10,000** per family plan in network
- **Not covered** per individual plan; **Not covered** per family plan out of network

All deductible payments count toward the family deductible amount, but the individual will never pay more than their individual deductible amount.

Out-of-pocket Limits

- **$7,150** per individual plan; **$14,300** per family plan in network
- **Not covered** per individual plan; **Not covered** per family plan out of network

All out-of-pocket payments count toward the family out-of-pocket limit. The individual will never pay more than their individual out-of-pocket amount.

Please note:

The deductible and out-of-pocket limits are separate for in-network and out-of-network services.

Network:

This plan has a regional network, where all participating providers throughout New England (MA, RI, CT, NH, and ME) are in-network.

Office Visits	Enhanced Tier	Standard Tier	Out-of-Network
Primary Care	$20 per visit	$35 per visit	Not Covered
Specialist*	$45 per visit		Not Covered
Urgent Care	$100 per visit		
Emergency Room	$200 per visit		
Doctors Online	$20 per visit		Not Covered
Chiropractic (limit 20 visits per year)	$45 per visit		Not Covered

Other Covered Services	Enhanced Tier	Standard Tier	Out-of-Network
Preventive Care	$0 per visit		Not Covered
Lab (non-hospital based/hospital based)	$30 per visit	$30/$45 per visit	Not Covered
X-ray (non-hospital based/hospital based)	$50/$60 per visit	$60/$75 per visit	Not Covered
High-end Radiology (non-hospital based/hospital based)	$200/$250 per visit	$250 per visit/ $500 per visit after deductible	Not Covered
Outpatient Surgery (non-hospital based/hospital based)	$0/$500 per visit	$0 per visit/ $1,000 per visit after deductible	Not Covered
Inpatient Services	$1,000 per visit	$2,000 per visit after deductible	Not Covered
Durable Medical Equipment	20% per service/device after deductible		Not Covered
Physical, Occupational, and Speech Therapy	$45 per visit		Not Covered
Prescriptions Drugs	**Retail (30 Day Supply)** $15-Tier 1; $50-Tier 2; $100-Tier 3; $200-Tier 4; $400-Tier 5 **Mail-Order (90 Day Supply)** $37.50-Tier 1; $125-Tier 2; $250-Tier 3; $1,200-Tier 4; N/A-Tier 5 Out-of-network not covered		

**Free foot and eye exams available for members with Diabetes (limit 1 exam per year)*

Members must select a Primary Care Provider (PCP) during enrollment. Failure to select a PCP may result in a reduction in benefits.

This is a summary of your Network Blue New England Options 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.

Plan Year: 2021