

# Understanding Your Benefits

## Registering Online at myBCBSRI

- Go to [myBCBSRI.com](http://myBCBSRI.com)
- Click on "Register Here"
- Follow the registration instructions provided

## Deductibles

- \$3,400** per individual plan;  
**\$6,800** 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

- \$6,350** per individual plan;  
**\$12,700** 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	In-Network	Out-of-Network
Primary Care	0% per visit after deductible	Not Covered
Specialist	0% per visit after deductible	Not Covered
Urgent Care	0% per visit after deductible	0% per visit after deductible
Emergency Room	0% per visit after deductible	0% per visit after deductible
Doctors Online	0% per visit after deductible	Not Covered
Chiropractic (limit 20 visits per year)	0% per visit after deductible	Not Covered

Other Covered Services	In-Network	Out-of-Network
Preventive Care	\$0 per visit	Not Covered
Diagnostic Lab/X-ray	0% per visit after deductible	Not Covered
High-end Radiology	0% per visit after deductible	Not Covered
Outpatient Surgery	0% per visit after deductible	Not Covered
Inpatient Services	0% per visit after deductible	Not Covered
Durable Medical Equipment	20% per service/device after deductible	Not Covered
Physical, Occupational, and Speech Therapy	0% per visit after deductible	Not Covered
Prescription Drugs	<p><b>Retail (30 Day Supply)</b> \$10*-Tier 1; \$45*-Tier 2; \$70*-Tier 3; \$90*-Tier 4; \$125*-Tier 5</p> <p><b>Mail-Order (90 Day Supply)</b> \$25*-Tier 1; \$112.50*-Tier 2; \$175*-Tier 3; \$270*-Tier 4; N/A-Tier 5</p> <p>Out-of-network not covered</p>	

\*Applicable once deductible is satisfied

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