Network Blue New England

Blue Cross Blue Shield of Rhode Island

100/Not Covered $4,000 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:

- $4,000 per individual plan; $8,000 per family plan in network
- Not Covered per individual plan; Not Covered per family plan out of network
- **Hybrid deductible**: 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

The following is the maximum amount you would pay out-of-pocket for covered healthcare services each year, including deductible, copays, and coinsurance.

- $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
- **Hybrid out-of-pocket**: 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.

What's Covered	What You Pay	
Service	**In-Network**	**Out-of-Network**
Preventive Care ▪ Adult preventive care ▪ Child preventive care ▪ Immunizations ▪ Preventive lab, X-ray, and imaging	$0 per visit	Not Covered
Primary Care Office Visits ▪ Adult primary care ▪ Adult gynecological exam ▪ Pediatric primary care	$25 per visit	Not Covered
Specialist Office Visits ▪ Specialty care ▪ Chiropractic* (limit 20 visits per year)	$40 per visit	Not Covered
▪ Routine Eye Exam (limit 1 visit per year) ▪ Non-routine eye exam	$0 per visit	Not Covered
Diabetics ▪ Foot exam (limit 1 visit per year) ▪ Eye exam (limit 1 visit per year)	$0 per visit	Not Covered
Outpatient Services ▪ Diagnostic lab	$25 per visit	Not Covered
▪ X-ray and imaging	$75 per visit	Not Covered
▪ Medical/surgical care ▪ High-end radiology (e.g., MRI/CT/PET), nuclear medicine and sleep studies	0% per visit after deductible	Not Covered

Registering Online

- Go to BCBSRI.com
- Click on "Log In to My Account", then click "Register now"
- Follow the registration instructions provided

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.

Mobile Access:

Your Blue Touch RI – Mobile App

- Employees can see health benefits and remaining deductible and out-of-pocket amounts, search for doctors and other providers, and much more.
- Download the app from the Apple or Google app store (iOS® is a registered trademark of Cisco in the U.S. and is used by Apple under license. Android is a trademark of Google Inc).

Your Blue Wire RI – Text Messages

- Members can receive secure personalized messages on their mobile devices, like reminders about flu shots and important tests; money-saving tips; benefit updates, and more.
- Call **1-844-779-8820** to sign up

Need Help?

Call Customer Service

- Locally: (401) 459-5000
- Outside Rhode Island: 1-800-639-2227
- TTY/TDD (Telecommunication Device for the Deaf) Users should call 711

Hours:
Monday – Friday, 8:00 a.m. to 8:00 p.m., Saturday – Sunday, 8:00 a.m. to 12 p.m., Eastern Time

What's Covered	What You Pay	
Service	**In-Network**	**Out-of-Network**
Inpatient Services ▪ Hospitalization ▪ Maternity ▪ Mental Health* ▪ Chemical dependency* ▪ Rehabilitation (limit 45 days per year)	0% per visit after deductible	Not Covered
Hospital Emergency Services*	$200 per visit	$200 per visit
Urgent Care*	$100 per visit	$100 per visit
Telemedicine Visits*	$25 per visit	Not Covered
Retail Based Clinic Visits*	$25 per visit	Not Covered
Ambulance ▪ Ground ▪ Air/Water	$50 per occurrence	$50 per occurrence
Durable Medical Equipment ▪ Medical supplies ▪ Diabetic supplies ▪ Prosthetic devices	20% per service/device after deductible	Not Covered
Physical, Occupational, and Speech* Therapy	20% per visit after deductible	Not Covered
Prescription Drugs	**Retail (30 Day Supply):** $10-Tier 1, $30-Tier 2; $50-Tier 3; $75-Tier 4; $125-Tier 5 **Mail-Order (90 Day Supply):** $25-Tier 1, $75-Tier 2; $125-Tier 3; $225-Tier 4; N/A-Tier 5 Out-of-network not covered $2 copay for certain Tier 1 drugs that treat asthma, diabetes, and COPD	
Pediatric Vision* (For dependents under age 19) ▪ Collection prescription glasses ▪ Standard lenses and lens options ▪ Collection contact lenses	0% per service	Not Covered

*This service does not require a referral

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

This PCP will be the center of the member's care and provide referrals for specialists, tests and other services.

This is a summary of your Network Blue New England 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.

Blue Cross Blue Shield of Rhode Island
www.bcbsri.com
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