Network Blue New England Options

Blue Cross Blue Shield of Rhode Island

100/Not Covered $5,000 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:

- $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
- **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	**Enhanced Tier**	**Standard Tier**	**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	$20 per visit	$35 per visit	Not Covered
Specialist Office Visits ▪ Specialty care ▪ Chiropractic* (limit 20 visits per year)	$45 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 (Non-Hospital Based) ▪ Diagnostic lab	$30 per visit		Not Covered
▪ X-ray and imaging	$50 per visit	$60 per visit	Not Covered
▪ Medical/surgical care	$0 per visit		Not Covered
▪ High-end radiology (e.g., MRI/CT/PET), nuclear medicine and sleep studies	$200 per visit	$250 per visit	Not Covered
Outpatient Services (Hospital Based) ▪ Diagnostic lab	$30 per visit	$45 per visit	Not Covered
▪ X-ray and imaging	$60 per visit	$75 per visit	Not Covered

continued

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	**Enhanced Tier**	**Standard Tier**	**Out-of-Network**
▪ Medical/surgical care	$500 per visit	$1,000 per visit after deductible	Not Covered
▪ High-end radiology (e.g., MRI/CT/PET), nuclear medicine and sleep studies	$250 per visit	$500 per visit after deductible	Not Covered
Inpatient Facility Services ▪ Hospitalization ▪ Rehabilitation (limit 45 days per year)	$1,000 per visit	$2,000 per visit after deductible	Not Covered
▪ Mental Health ▪ Chemical dependency	$1,000 per visit		Not Covered
▪ Maternity	0% per visit after deductible		Not Covered
Inpatient Professional Services ▪ Physician hospital visits ▪ Surgical care	$0 per visit		Not Covered
Hospital Emergency Services	$200 per visit		$200 per visit
Urgent Care	$100 per visit		$100 per visit
Telemedicine Visits	$20 per visit		Not Covered
Retail Based Clinic Visits	$35 per visit		Not Covered
Ambulance ▪ Ground ▪ Air/Water	$50 per occurrence		$50 per occurrence
Durable Medical Equipment	20% per service/device after deductible		Not Covered
Physical, Occupational, and Speech Therapy	$45 per visit		Not Covered
Prescription 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 $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 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

Blue Cross Blue Shield of Rhode Island
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