

# Blue Choice New England

\$6,000 Deductible

## Understanding Your Benefits

### Deductibles

- **\$6,000** per individual plan;  
**\$12,000** per family plan in network

**\$10,000** per individual plan;  
**\$20,000** per family plan out of network

Aggregate deductible: All deductible payments count toward the family deductible, one or all can meet it.

### Out-of-pocket Limits

- **\$6,850** per individual plan;  
**\$13,700** per family plan in network
  - **\$13,700** per individual plan;  
**\$27,400** 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
<b>Primary Care</b>	\$30 per visit	20% per visit after deductible
<b>Specialist</b>	\$50 per visit	20% per visit after deductible
<b>Behavioral Health</b>	\$30 per visit	20% per visit after deductible
<b>Urgent Care</b>	\$50 per visit	\$50 per visit
<b>Emergency Room</b>	\$200 per visit	\$200 per visit
<b>Doctors Online</b>	\$30 per visit	Not Covered
<b>Chiropractic</b> (limit 20 visits per year)	\$50 per visit	20% per visit after deductible

Other Covered Services	In-Network	Out-of-Network
<b>Preventive Care</b>	\$0 per visit	20% per visit after deductible
<b>Diagnostic Lab/X-ray</b>	0% per visit	20% per visit after deductible
<b>High-end Radiology</b>	0% per visit after deductible	20% per visit after deductible
<b>Outpatient Surgery</b>	0% per visit after deductible	20% per visit after deductible
<b>Inpatient Services</b>	0% per visit after deductible	20% per visit after deductible
<b>Durable Medical Equipment</b>	20% per service/device after deductible	20% per service/device after deductible
<b>Physical, Occupational, and Speech Therapy</b> (limit 30 visits each per year)	20% per visit after deductible	20% per visit after deductible

*\*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.

# 4-Tier Plan



The BCBSRI formulary (drug list) covers a wide range of commonly prescribed medications. The chart below shows how the drugs are divided into four “tiers”.

## Your Prescription Drug Coverage

### Online member account

Create your member account at [BlueCareConnectRI.com](http://BlueCareConnectRI.com) or download the **BlueCare Connect** app to get started.

Once you are signed in to your **BlueCare Connect** account, select "**Benefits**" to access your Pharmacy information and formulary.

### Extended Supply Network

The Extended Supply Network (ESN) allows 90 day fills at retail pharmacies.

Service	Copayment per 30-day supply	Mail order 90-day supply	Retail 90-day supply
<b>Tier 1</b> <ul style="list-style-type: none"><li>Low-cost generics</li></ul>	\$7*	\$17.50	\$21
<b>Tier 2</b> <ul style="list-style-type: none"><li>Higher-cost generics</li><li>Preferred brand name drugs</li></ul>	\$25	\$62.50	\$75
<b>Tier 3</b> <ul style="list-style-type: none"><li>Highest cost generics</li><li>Non-preferred brand name drugs</li></ul>	\$40	\$120	\$120
<b>Tier 4</b> <ul style="list-style-type: none"><li>Specialty drugs</li></ul>	\$65	Not Covered	Not Covered

*\*\$2 copay for certain tier 1 drugs for asthma, diabetes and COPD (Network Blue New England, Blue Choice, Network Blue New England Options, and VantageBlue plans ONLY)*

*This is a summary of your pharmacy 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.*



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