

## City of Providence Standard Plan Benefit Summary

**This benefit summary applies to the following groups:**

- |              |                      |                       |             |
|--------------|----------------------|-----------------------|-------------|
| • CCC1/1F451 | • 6L61-Pkg 001/1F450 | • P6L61-Pkg 001/1F466 | • PT7/1F445 |
| • 4H75/1F448 | • CCC1A/1F461        | • PFC1/1F457          | • PT8/1F446 |
| • 5D05/1F414 | • CPC1/1F453         | • PR4/1F444           | • PT9/1F447 |
| • 5H52/1F449 | • CPC1C/1F462        | • PR4X-Pkg 001/1F458  | • PW2/1F426 |

HealthMate Coast-to-Coast focuses on preventive care, setting the foundation for continued good health. Plus, you benefit from:

- **An extensive nationwide network.** You can receive in-network coverage from more than 536,000 doctors and 4,300 hospitals through the BlueCard® PPO network.
- **No paperwork for in-network services.** Simply show your BCBSRI member ID card, and the provider will do the rest. You're only responsible for paying any applicable copayment, coinsurance, or deductible.
- **The freedom to choose.** If you visit an out-of-network provider for covered services, simply pay for the service up front and then file a claim for reimbursement. You may have to pay higher out-of-pocket costs when you visit non-network providers. Please see your plan's subscriber agreement for details or call Customer Service.

	Within the BlueCard® PPO Network you pay:	Outside of the BlueCard® PPO Network you pay:	Notes
<b>Deductible</b>	None	\$100 per individual	For family coverage: Up to a maximum of three family members must meet the individual amount per calendar year.
<b>Coinsurance</b>	0%	20%	
<b>Out-of-pocket maximum</b>	None	\$1,000 per individual	For family coverage: Up to a maximum of three family members must meet the individual amount per calendar year. Once you exceed this amount, we will pay up to our allowance for most covered services. Deductibles and copayments do not apply to your out-of-pocket maximum.
<i>Please remember that you are responsible for paying any copayment, coinsurance, and/or deductible to your provider. This is a mandatory requirement when receiving healthcare services. Copayments are due at the time of service. Any coinsurance and/or deductible amounts can be paid at the time of service or within the time frame specified by your provider. Coinsurance and deductible amounts are shown on the explanation of benefits (EOB) that we send to you after processing your claim. You must pay the provider the total amount shown in the section labeled "Your Responsibility" on the EOB.</i>			
<b>Preventive Care</b>			
<b>Adult preventive care</b>	\$10	\$10 plus 20% after deductible	Includes one physical exam and one gynecological exam per calendar year.
<b>Pediatric preventive care</b>	\$10	\$10 plus 20% after deductible	
<b>Immunizations</b>	\$0	20% after deductible	Includes adult and pediatric immunizations. An office visit copayment will apply if the provider bills for the immunization administration in addition to an office visit.
<b>Lab services, machine tests, and X-rays</b>	\$0	20% after deductible	Includes Pap smears, screening mammograms, and prostate-specific antigen (PSA) tests.
<b>Office Visits</b>			
<b>Personal care physician (PCP)</b>	\$10	\$10 plus 20% after deductible	
<b>Specialist</b>	\$10	\$10 plus 20% after deductible	Chiropractic visits are limited to 12 per calendar year. Routine eye exams are limited to 1 per calendar year. \$15 copayment for dermatologist and allergist visits.

	Within the BlueCard® PPO Network you pay:	Outside of the BlueCard® PPO Network you pay:	Notes
<b>Outpatient Services</b>			
<b>Outpatient medical/surgical care</b> (facility and doctor services)	\$0	20% after deductible	
<b>Lab services, machine tests, and X-rays</b> (diagnostic)	\$0	20% after deductible	
<b>Inpatient Services</b>			
<b>Inpatient hospital services</b> - acute care - maternity	\$0	20% after deductible	Unlimited days at a general or specialty hospital. Up to 45 days per calendar year for physical rehabilitation.
<b>Mental Health and Chemical Dependency Treatment Services</b>			
<b>Inpatient</b>	\$0	20% after deductible	
<b>Outpatient</b>	\$0	20% after deductible	
<b>Office Visits</b>	\$10	\$10 plus 20% after deductible	
<b>Urgent Care or Emergency Care</b>			
<b>Urgent care center</b>	\$10	\$10 plus 20% after deductible	
<b>Emergency room care</b>	\$25	\$25	If emergency room visit results in hospital admission, \$25 copayment is waived. You may be billed an additional specialist copayment if you are seen by a specialist in the emergency room.
<b>Ambulance services</b>	\$50	\$50	Coverage for medically necessary/emergency services. Air and water ambulances are limited to a maximum of \$3,000 per occurrence.
<b>Additional Services</b>			
<b>Prescription drugs</b>	See prescription drug insert for details. Prescription drug copayments and coinsurance do not apply to your out-of-pocket maximum.		
<b>Physical/occupational therapy</b>	20%	20% after deductible	
<b>Durable medical equipment (DME)</b>	20%	20% after deductible	Must be purchased from a participating DME vendor. Pharmacies are NOT participating in the DME network.
<b>Home and hospice care</b>	\$0	20% after deductible	Includes physician, nurse, and home health aide visits.

*This grid provides a general summary of your HealthMate Coast-to-Coast 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 our Customer Service Department at (401) 459-5000 or 1-800-639-2227 (outside of Rhode Island). If you have any questions about receiving medical care, call your personal care physician.*

## Key Terms

**Coinsurance:** The percentage of our allowance that you must pay for a covered healthcare service.

**Copayment:** A fixed dollar amount that you must pay for a covered healthcare service.

**Deductible:** A fixed amount that you must pay for covered healthcare services each calendar year before we start to pay for those services.

**Out-of-pocket maximum:** Highest amount of coinsurance that you must pay each calendar year for certain covered healthcare services.

**Personal care physician (PCP):** Includes family practitioners, internists, and pediatricians.

**Specialist:** Includes office visits to all other medical providers who specialize in a certain area of medicine, such as but not limited to: oncology, cardiology, ophthalmology, dermatology, or allergy.

## How Your Deductible Works

Your plan features a deductible for services provided outside the BlueCard network. The deductible is the amount of covered expenses you must pay per calendar year before we start to pay for covered services.

- Three family members must satisfy the individual deductible. Once the third family member meets his or her individual deductible, the family deductible is satisfied.
- Once the out-of-network family deductible is met, the family only needs to pay coinsurance (if applicable) up to the out-of-pocket maximum.

The family out-of-pocket maximum accumulates the same way as the family deductible.



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