

Providence Police Retirees – Before 7/77 – CP2/1F428
 Providence Police Retirees – After 7/77 – CP4/1F429
 Providence Retirees EXT BEN – Before 1995 – MCCC1/1F463
 Providence Police Retirees EXT BEN – MCPC1/1F464
 Providence Fire Retirees EXT BEN – MPFC1/1F465
 Providence Fire Dept. Retirees – After 6/87– PF2/1F440
 Providence Fire Dept. Retirees – Before 6/87– PF3/1F441
 Providence Retirees Class A – Before 1982 – PR2/1F442
 Providence Retirees Class A – After 1982 – PR3/1F443

Benefit Summary

ClassicBlue, our traditional indemnity plan,
 combines comprehensive benefits with complete freedom of choice.

- **An extensive nationwide network.** You can receive in-network coverage from our extensive network of hospitals and providers.
- **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® Traditional Network you pay:	Outside of the BlueCard® Traditional Network you pay:	Notes
<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>			
Preventive Care			
Adult preventive care	20%*	20%*	Includes one physical exam and one gynecological exam per calendar year.
Pediatric preventive care	\$10	\$10	Includes routine physicals.
Immunizations	\$0	\$0	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.
Lab services, machine tests, and X-rays	\$0	\$0	Includes Pap smears, screening mammograms, and prostate-specific antigen (PSA) tests.
Office Visits			
Personal care physician (PCP)	20%*	20%*	
Specialist	20%*	20%*	Routine eye exams are not covered.
Outpatient Services			
Outpatient medical/ surgical care (facility and doctor services)	\$0	\$0	
Lab services, machine tests, and X-rays (diagnostic)	\$0	\$0	

*After meeting the \$50 annual Major Medical deductible. Deductibles vary by plan.

continued

	Within the BlueCard® Traditional Network you pay:	Outside of the BlueCard® Traditional Network you pay:	Notes
Inpatient Services			
Inpatient hospital services - acute care - maternity	\$0	\$0	Unlimited days at a general or specialty hospital. Up to 45 days per calendar year for physical rehabilitation.
Mental Health and Chemical Dependency Treatment Services			
Inpatient	\$0	\$0	
Outpatient	\$0	\$0	
Office Visits	20%*	20%*	
Urgent Care or Emergency Care			
Urgent care center	20%*	20%*	
Emergency room care	\$0	\$0	You may be billed an additional specialist copayment if you are seen by a specialist in the emergency room.
Ambulance services	\$50	\$50	Coverage for medically necessary/emergency services. Air and water ambulances are limited to a maximum of \$3,000 per occurrence.
Additional Services			
Prescription drugs	20%*	20%*	
Physical/occupational therapy	\$0	\$0	Coverage for services of a hospital-based therapist and within 30 days following a hospital stay, home care, or surgical procedure; otherwise covered at 80 percent after major medical deductible.
Durable medical equipment (DME)	20%*	20%*	Must be purchased from a participating DME vendor. Pharmacies are NOT participating in the DME network.
Home and hospice care	\$0	\$0	Includes physician, nurse, and home health aide visits.

*After meeting the \$50 annual Major Medical deductible. Deductibles vary by plan.

This grid provides a general summary of your ClassicBlue 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.

Major Medical 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.



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