

Providence Police Department - CP1 pkg 006/1F416 pkg 001

Providence Police Retirees - 7/2011 to Present - P6L61 pkg 002/1F466 pkg 002

Benefit Summary

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
Deductible	None	\$100 per individual \$300 per family	For family coverage: Up to a maximum of three family members must meet the individual amount per calendar year. Flat dollar copayments do not apply to the deductible.
Coinsurance	As noted below	As noted below	
Out-of-pocket maximum	None	\$1,000 per individual \$3,000 per family	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.
Hospital Copayment	None	\$200 per occurrence plus applicable coinsurance, depending on type of service	Includes all inpatient hospital services, surgery provided in an outpatient hospital setting or ambulatory surgical center and most outpatient hospital services. Up to three family must meet this per calendar year.

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.

Preventive Care

Adult preventive care	\$15	\$15 plus 20% after deductible	Includes one physical exam and one gynecological exam per calendar year.
Pediatric preventive care	\$15	\$15 plus 20% after deductible	
Immunizations	\$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.
Lab services, machine tests, and X-rays	\$0	20% after deductible	Includes Pap smears, screening mammograms, and prostate-specific antigen (PSA) tests.

Office Visits

Personal care physician (PCP)	\$15	\$15 plus 20% after deductible	
Specialist	\$20	\$20 plus 20% after deductible	Chiropractic visits are limited to 12 per calendar year. Routine eye exams are limited to 1 per calendar year.

Outpatient Services

Outpatient surgical care in a doctor's office	\$0	20% after deductible	
Lab services, machine tests, and X-rays (diagnostic)	\$0	20% after deductible	

	Within the BlueCard® PPO Network you pay:	Outside of the BlueCard® PPO Network you pay:	Notes
Inpatient Services			
Inpatient hospital services • Acute care • Maternity	\$0	\$200 hospital copayment per occurrence plus 20% coinsurance (Deductible does not apply.)	Unlimited days at general or specialty hospital. Up to 45 days per calendar year for physical rehabilitation. See "Hospital Copayment" notes on first page.
Mental Health and Chemical Dependency Treatment Services			
Inpatient	\$0	20% after deductible	
Outpatient	\$0	20% after deductible	
Office Visits	\$20	\$20 plus 20% after deductible	
Urgent Care or Emergency Care			
Urgent care center	\$20	\$20 plus 20% after deductible	
Emergency room care	\$100	\$100	If emergency room visit results in hospital admission, \$100 copayment is waived. 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			
Physical/occupational therapy	20%	20% after deductible	
Durable medical equipment (DME)	20%	20% after deductible	Must be purchased from a participating DME vendor. Pharmacies are NOT participating in the DME network.
Home and hospice care	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 benefit booklet 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 their individual deductible, the family deductible is satisfied.
- Once the out-of-network family deductible is met, the family only needs to pay coinsurance and copayments (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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03/12

CUST-11361



Benefit Highlights

PROVIDENCE POLICE DEPARTMENT

Product Name: Delta Dental Premier

Plan Type: National Coverage

The information listed here is not a guarantee of payment. Payment is based on the Delta Dental allowance for each procedure. To be covered, services must be dentally necessary and in accordance with Delta Dental's treatment guidelines. All services must be performed in a dental office. These benefits are listed according to the level of coverage (i.e. 100%,80%) . Your group number is 1105-0002. Coverage for benefits with time limitations (i.e. 6,12,24,36 or 60 months) is calculated to the exact day.

The annual maximum is: \$1,200.00 per member per calendar year
The annual deductible is: \$0.00
The maximum lifetime cap: Unlimited

Pretreatment estimates are recommended for underlined procedures.

Plan pays 100%; Member Coinsurance 0%

- Oral exam - once per calendar year performed by a general dentist
- Cleaning - twice per calendar year
- Fluoride treatment - for children under age 19 once per calendar year
- Bitewing x-rays - one set per calendar year
- Complete x-ray series or panoramic film once every 36 months
- Single x-rays as required
- Palliative treatment (minor procedures necessary to relieve acute pain) twice per calendar year
- Amalgam (silver) fillings. Composite (white) fillings on front teeth only. For composite fillings on back teeth, the plan pays up to what would have been paid for an amalgam filling. Patient is responsible for the balance up to the dentist's charge.
- Space maintainers once every 60 months for lost deciduous (baby) teeth
- Extractions and other routine oral surgery when not covered by a patient's medical plan
- General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures
- Root canal therapy
- Repairs to existing partial or complete dentures once per calendar year
- Recementing crowns or bridges once every 60 months
- Rebasing or relining of partial or complete dentures once every 60 months
- Crowns over natural teeth, build ups, posts and cores - replacement limited to once every 60 months

Plan pays 50%; Member Coinsurance 50%

- Periodontal maintenance following active therapy - two per year
- Bridges, build ups, posts and cores, crowns over implants - replacement limited to once every 60 months
- Partial and complete dentures - replacement limited to once every 60 months
- Root planing and scaling once per quadrant every 24 months.
- Osseous (bone) surgery once per quadrant every 24 months (bone grafts are not covered).
- Gingivectomies once per site every 24 months.
- Soft tissue grafts once per site every 60 months
- Crown lengthening once per site every 60 months

Orthodontics:

Plan pays 50%; Member Coinsurance 50%

- Braces and related services for dependent children under the age of 19

Lifetime maximum (orthodontics only) is \$1,200.00

Dependent coverage - Dependent children are covered up until the end of the month that they turn age 26.

Exclusions & Limitations

All claims must be filed within one year of the date of service.

Unless specifically covered by your dental plan, the following are not covered:

- Services that do not qualify for payment according to our dental treatment guidelines. (These guidelines assist Delta Dental in making determinations as to whether services are covered and whether a particular service is the least costly, clinically acceptable method of prevention, diagnosis or treatment. A service may not qualify for coverage under these guidelines even though it was performed or recommended by a dentist.)
- Any services that are not specifically covered in your group's Certificate of Coverage.
- Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trustee or similar person or group.
- An illness or injury that Delta Dental determines is employment related.
- Services you would not be required to pay for if you did not have this Delta Dental coverage.
- Services provided by a dentist who is a member of your immediate family.
- An illness, injury or dental condition for which benefits are, or would have been available, through a government program if you did not have this Delta Dental coverage.
- Services rendered by someone other than a licensed dentist or a licensed hygienist operating as authorized by applicable law.
- Specialty exams.
- Consultations.
- Disorders related to the temporomandibular joint (TMJ) including night guards and surgery.
- Services to increase the height of teeth or restore occlusion.
- Restorations required because of erosion, abrasion or attrition.
- Services meant primarily to change or improve your appearance.
- Occlusal guards.
- Implants.
- Bone grafts.
- Splinting and other services to stabilize teeth.
- Prescription drugs, lab exams or reports.
- Guided tissue regeneration.
- Temporary bridges or crowns.
- Services related to congenital abnormalities.
- General anesthesia/intravenous sedation for non-surgical extractions, diagnostic, preventive or any restorative services.
- General anesthesia/intravenous sedation administered by anyone other than a dentist.

Delta Dental also reserves the right to adopt and to apply, from time to time, such administrative policies as it deems reasonable in approving the eligibility of subscribers and the appropriateness of treatment plans and related charges.