

Providence 1033 School Aides/Bus Monitors Before 2004 - PT3/1F423

Providence 1033 School Dept. B.E.S.T. Before 2004 - PT5/1F425

## 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
<b>Deductible</b>	None	\$100 per individual \$300 per family	For family coverage: Up to a maximum of \$300 aggregated between all family members per calendar year.
<b>Coinsurance</b>	As noted below	As noted below	
<b>Out-of-pocket maximum</b>	None	\$1,000 per individual \$3,000 per family	For family coverage: Up to a maximum of \$3,000 aggregated between all family members 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.
<b>Hospital Copayment</b>	\$50 per occurrence	\$50 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 \$100 per individual, but not to exceed \$300 per family per calendar year. In and out-of-network hospital copayment maximums are combined.

*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

<b>Adult preventive care</b>	\$15	\$15 plus 20% after deductible	Includes one physical exam and one gynecological exam per calendar year.
<b>Pediatric preventive care</b>	\$15	\$15 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.

### Office Visits

<b>Personal care physician (PCP)</b>	\$15	\$15 plus 20% after deductible	
<b>Specialist</b>	\$15	\$15 plus 20% after deductible	Chiropractic visits are limited to 12 per calendar year. Routine eye exams are limited to 1 per calendar year. Allergy and dermatologists office visits have a \$20 copayment.

### Outpatient Services

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

	Within the BlueCard® PPO Network you pay:	Outside of the BlueCard® PPO Network you pay:	Notes
<b>Inpatient Services</b>			
<b>Inpatient hospital services</b> • Acute care • Maternity	\$50 hospital copayment per occurrence	\$50 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.
<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>	\$15	\$15 plus 20% after deductible	
<b>Urgent Care or Emergency Care</b>			
<b>Urgent care center</b>	\$15	\$15 plus 20% after deductible	
<b>Emergency room care</b>	\$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.
<b>Ambulance services</b>	\$50	\$50	Coverage for medically necessary/emergency services. Water ambulances are limited to a maximum of \$3,000 per occurrence. Air ambulances are not covered.
<b>Additional Services</b>			
<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.

*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.

- All family members' expenses accumulate to the family deductible. The deductible can be satisfied by one or more members of the family.
- 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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