Blue Cross Blue Shield of Rhode Island **HealthMate Coast-to-Coast**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2014 - 06/30/2015
Coverage for: See below **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.BCBSRI.com or by calling 1-800-639-2227 or (401) 459-5000.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For In Network providers **$2000** for an individual plan / **$4000** for a family plan. For Out-of-Network providers **$4000** for an individual plan / **$8000** for a family plan. Doesn't apply to preventive services, services with a fixed dollar copay, prescription drugs and diagnostic testing.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For In Network providers **$6000** for an individual plan / **$12000** for a family plan. For Out-of-Network providers **$12000** for an individual plan / **$24000** for a family plan.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Questions: Call 1-800-639-2227 or (401) 459-5000 or TDD 1-888-252-5051 or visit us at www.BCBSRI.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.BCBSRI.com or call 1-800-639-2227 or (401) 459-5000 or TDD 1-888-252-5051 to request a copy.

Does this plan use a network of providers?	Yes, this plan uses in-network providers. See www.BCBSRI.com or call 1-800-639-2227 or (401) 459-5000 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit	20% coinsurance after deductible	——none——
	Specialist visit	$25 copay per visit	20% coinsurance after deductible	——none——
	Other practitioner office visit	$25 copay per visit	20% coinsurance after deductible	Chiropractic Services are limited to 12 visits per year
	Preventive care/screening/immunization	No Charge	20% coinsurance after deductible	For additional details, please see your plan documents or visit www.BCBSRI.com/providers/policies
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance after deductible	Preauthorization is recommended for certain services
	Imaging (CT/PET scans, MRIs)	No Charge after deductible	20% coinsurance after deductible	Preauthorization is recommended

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.BCBSRI.com.	Tier 1 generally low cost generic drugs	$7 copay per prescription (retail) $17.50 copay per prescription (mail-order)	Not covered	No Charge for certain preventive drugs
	Tier 2 generally high cost generic and preferred brand name drugs	$30 copay per prescription (retail) $75 copay per prescription (mail-order)	Not covered	Preauthorization is required for certain drugs
	Tier 3 non- preferred brand name drugs	$50 copay per prescription (retail) $125 copay per prescription (mail-order)	Not covered	Preauthorization is required for certain drugs
	Tier 4 specialty prescription drugs	$75 copay per prescription (specialty pharmacy only)	50% coinsurance	Infertility drugs: 20% coinsurance; Preauthorization is required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible	20% coinsurance after deductible	Preauthorization is recommended
	Physician/surgeon fees	No Charge after deductible	20% coinsurance after deductible	——none——
If you need immediate medical attention	Emergency room services	$100 copay per visit	$100 copay per visit	Copay waived if admitted
	Emergency medical transportation	$50 copay per trip	$50 copay per trip	——none——
	Urgent care	$25 copay per urgent care center visit	$25 copay per urgent care center visit	Applies to the visit only. If additional services are provided additional out of pockets costs would apply based on services received.

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	20% coinsurance after deductible	45 day limit at an inpatient rehabilitation facility; Preauthorization is recommended
	Physician/surgeon fee	No Charge after deductible	20% coinsurance after deductible	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/office visit No Charge after deductible for outpatient services	20% coinsurance after deductible/office visit 20% coinsurance after deductible for outpatient services	Preauthorization is recommended for certain services
	Mental/Behavioral health inpatient services	No Charge after deductible	20% coinsurance after deductible	Preauthorization is recommended
	Substance use disorder outpatient services	$25 copay/office visit No Charge after deductible for outpatient services	20% coinsurance after deductible/office visit 20% coinsurance after deductible for outpatient services	Preauthorization is recommended for certain services
	Substance use disorder inpatient services	No Charge after deductible	20% coinsurance after deductible	Preauthorization is recommended
If you are pregnant	Prenatal and postnatal care	No Charge after deductible	20% coinsurance after deductible	——————none——————
	Delivery and all inpatient services	No Charge after deductible	20% coinsurance after deductible	Preauthorization is recommended

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge after deductible	20% coinsurance after deductible	——————none——————
	Rehabilitation services	20% coinsurance after deductible	20% coinsurance after deductible	Includes Physical/Occupational and Speech Therapy. Physical and Occupational Therapy is limited to 30 visits; Preauthorization is recommended after the first 10 visits (combined for in and out of network). Speech Therapy is limited to 30 visits; Preauthorization is recommended for all visits
	Habilitative services	20% coinsurance after deductible	20% coinsurance after deductible	Includes Physical/Occupational and Speech Therapy. Physical and Occupational Therapy is limited to 30 visits; Preauthorization is recommended after the first 10 visits (combined for in and out of network). Speech Therapy is limited to 30 visits; Preauthorization is recommended for all visits
	Skilled nursing care	No Charge after deductible	20% coinsurance after deductible	Custodial care is not covered; Preauthorization is recommended
	Durable medical equipment	20% coinsurance after deductible	20% coinsurance after deductible	Preauthorization is recommended for certain services.
	Hospice service	No Charge after deductible	20% coinsurance after deductible	Preauthorization is recommended
If your child needs dental or eye care	Eye exam	$25 copay	20% coinsurance after deductible	Limited to one routine eye exam per year.
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Cosmetic surgery • Dental care (Adult)	• Dental check-up, child • Glasses, child • Long-term care	• Routine foot care unless to treat a systemic condition • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric Surgery • Chiropractic care • Hearing aids	• Infertility treatment • Most coverage provided outside the United States. Contact Customer Service for more information. • Private-duty nursing	• Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-639-2227 or (401) 459-5000 or TDD 1-888-252-5051. You may also contact your state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact your state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-639-2227.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-639-2227.
如果需要中文的帮助，请拨打这个号码 1-800-639-2227.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-639-2227.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,480
- **Patient pays** $2,060

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$30
Coinsurance	$0
Limits or exclusions	$30
Total	**$2,060**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,360
- **Patient pays** $2,040

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,600
Copays	$400
Coinsurance	$0
Limits or exclusions	$40
Total	**$2,040**

These examples are based on coverage for an individual plan.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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