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: 07/01/2016 - 06/30/2017**
**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 **$500** for an individual plan / **$1000** for a family plan.<br>For Out-of-Network providers **$1000** for an individual plan / **$2000** for a family plan.<br>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 **$1500** for an individual plan / **$3000** for a family plan.<br>For Out-of-Network providers **$3000** for an individual plan / **$6000** 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 | $20 copay per visit | 20% coinsurance after deductible | none |
| | Specialist visit | $30 copay per visit | 20% coinsurance after deductible | none |
| | Other practitioner office visit | $30 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**<br><br>More information about **prescription drug coverage** is available at www.BCBSRI.com. | Tier 1 generally low cost generic drugs | $10 copay per prescription (retail)<br>$25 copay per prescription (mail-order) | Not covered | No Charge for certain preventive drugs |
| | Tier 2 generally high cost generic and preferred brand name drugs | $20 copay per prescription (retail)<br>$50 copay per prescription (mail-order) | Not covered | Preauthorization is required for certain drugs |
| | Tier 3 non- preferred brand name drugs | $30 copay per prescription (retail)<br>$75 copay per prescription (mail-order) | Not covered | Preauthorization is required for certain drugs |
| | Tier 4 specialty prescription drugs | $50 copay per prescription (specialty pharmacy only) | 50% coinsurance | Preauthorization is required for certain drugs; Infertility drugs: 20% coinsurance |
| **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 | $150 copay per visit | $150 copay per visit | Copay waived if admitted |
| | Emergency medical transportation | $50 copay per trip | $50 copay per trip | ——————none—————— |
| | Urgent care | $30 copay per urgent care center visit | $30 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 | $30 copay/office visit<br>No Charge after deductible for outpatient services | 20% coinsurance after deductible/office visit<br>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 | $30 copay/office visit<br>No Charge after deductible for outpatient services | 20% coinsurance after deductible/office visit<br>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 (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 (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 | $30 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** $6,970
- **Patient pays** $570

**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 | $500 |
| Copays | $40 |
| Coinsurance | $0 |
| Limits or exclusions | $30 |
| **Total** | **$570** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,060
- **Patient pays** $1,340

**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 | $500 |
| Copays | $600 |
| Coinsurance | $200 |
| Limits or exclusions | $40 |
| **Total** | **$1,340** |

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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