

**CITY OF PAWTUCKET, R.I.**  
**REQUEST FOR PROPOSALS**

<u>Item</u>	<u>Due Date</u>
Health Insurance Stop-Loss Coverage	Thursday, June 13, 2013 3:00 P.M.

**INTRODUCTION**

The City of Pawtucket (hereinafter referred to as the City) is requesting quotations for stop-loss coverage for their health plan for the plan year July 2013 – June 2014. Proposals are requested for specific only stop loss insurance according to the deductible levels outlined in the Proposal Pricing Form.

Please email your quotations to David Clemente, Purchasing Agent at [dclemente@pawtucketri.com](mailto:dclemente@pawtucketri.com) with a copy to Peter Savage at [psavage@cookandcompany.com](mailto:psavage@cookandcompany.com). The quotations are due at 3:00 p.m. on Thursday, June 13, 2013. The subject line of your email should read "Stop Loss RFP – Due 6/13/13."

Any proposal received after this time may be rejected. The City reserves the right to accept or reject any or all proposals in the best interest of the City. The City reserves the right to reject any RFP response that does not meet the minimum criteria, or does not completely answer all questions posed in this "Request for Proposals." The City reserves the right to independently verify the accuracy of information supplied in the RFP response. The City reserves the right to reject any RFP response that is not submitted in the requested format or not properly signed.

Questions and requests for additional information should be emailed to Peter Savage at [psavage@cookandcompany.com](mailto:psavage@cookandcompany.com). The deadline is 4 p.m. on June 6, 2013.

Completed proposals must include:

- \* Signed Letter of Transmittal
- \* Agreement with Minimum Criteria
- \* Policy Confirmation
- \* Sample Policy
- \* Anti-Kickback Acknowledgement

For pertinent underwriting information, please see Appendix A – Underwriting Data.

**MINIMUM CRITERIA**

Responses to this Request for Proposal must meet all of the Minimum Criteria listed below in order for the proposal to be considered.

- Proposer must respond to all questions and requests of this RFP and submit all items, data, information, and reports requested.
- Reinsurance policy must provide coverage over the City's health benefits plans administered by Blue Cross Blue Shield of Rhode Island and must have accepted both as a third party administrator.
- The proposal prices must be all-inclusive. That is, the RFP must include costs of reinsuring as required; claims tracking, filing, and reporting; broker commissions; taxes; and any other costs which may accrue to proposer or carrier as a result of this reinsurance contract, should it be awarded.
- The reinsurance company must be rated (A-) or better by A.M. Best and be an admitted carrier in Rhode Island.
- The quoted rates must be valid for 60 days from the proposal due date.
- Proposer must certify that a complete contract with no contingencies will be issued within 30 days of the acceptance of the proposal or the City will have the option to re-award the contract to another bidder.
- Proposer must have the capability to electronically track and file all claims associated with the reinsurance contract.
- The City reserves the right to interview proposers and to visit their offices prior to reaching a final decision on the award of the contract.
- The reinsurance carrier must include as covered expenses all actual claim charges paid by the self-insured plans, as specified in the plan document.
- Proposer must certify that regulations mandated by the Federal Health Care Reform Act during the policy period, will be covered by the policy.

The undersigned certifies that it understand and will comply with all of the above criteria.

Name: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

**POLICY CONFIRMATION**

Please confirm that:

- a. The policy covers dependents as well as the subscribers who are covered under the plan.
- b. There are no exclusions for those plan members who are not actively at work.
- c. There are no pre-existing condition exclusions.
- d. There are no waiting periods other than those that may be provided in the Plan.
- e. Mental and nervous services are covered at the levels mandated by the State of Rhode Island and the federal government.
- f. Prescription drugs are covered in accordance with the Plan Document.
- g. The policy covers non-Medicare retirees properly enrolled in the plan according to the Plan Document.
- h. The reinsurer will designate state surcharges required by Massachusetts, New York and Maine as eligible expenses.
- i. Any individual who is being covered under a separate deductible will be clearly identified.

The undersigned confirms the policy complies with the above requirements.

Name: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

**CITY OF PAWTUCKET**  
**PROPOSAL PRICING FORM**

**Specific Reinsurance**

Name and Address of Reinsurance Carrier: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name and Address of Broker Submitting Quote: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Carriers current A.M. Best Rating: \_\_\_\_\_

Enrollment      Individual Contracts:      495  
                         Family Contracts:          1613  
                         Total Contracts:              2108

<u>Specific Level</u>	<u>Claims Incurred in/</u>	<u>Claims Paid in</u>	<u>Monthly Ind Rate</u>	<u>Monthly Family Rate</u>	<u>Annual Premium</u>
\$250,000	12	24	_____	_____	_____
\$275,000	12	24	_____	_____	_____

Annual Maximum Per Covered Individual: \$2,000,000  
No Lifetime Maximum

Commission: \_\_\_\_\_

Commission/Tracking and Filing Fee, etc. paid to any other entity:

Amount: \_\_\_\_\_

Paid to: \_\_\_\_\_

\_\_\_\_\_  
(Signature of individual(s) authorized to bind broker/agent and carrier)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Name of Company)

**APPENDIX A - UNDERWRITING DATA**  
**CITY OF PAWTUCKET**

**SELF-FUNDED PLANS**

**I. ENROLLMENT INFORMATION:**

<u>Plan</u>	<u>Subscribers</u>	
	<u>Individual</u>	<u>Family</u>
<u>City</u>		
1. Classic	24	138
2. Healthmate	182	577
3. Blue Chip	0	10
<u>School</u>		
1. Classic	62	109
2. Healthmate	224	773
3. Blue Chip	3	6

**II. IN-FORCE SPECIFIC REINSURANCE COVERAGE**

Level: \$275,000

Term: Incurred Months 12                      Paid Months 24

Monthly Rates: Individual \$25.53                      Family \$25.53

Carrier: HM Life

Lifetime Maximum: \$2,000,000

Lasers: None

**III. Please refer to the following attachments as needed:**

- a) Census & Membership List
- b) Large Loss Information
- c) Schedule of Benefits

## **ANTI-KICKBACK ACKNOWLEDGMENT**

### **ALL BIDDERS/OFFERORS MUST ATTEST TO THE FOLLOWING:**

The vendor acknowledges, under the pains and penalties of perjury, that he/she has not been offered, paid, or solicited for any contribution or compensation, nor has he/she been granted a gift, gratuity, or other consideration, either directly or indirectly by any officer, employee or member of the governing body of the City of Pawtucket who exercises any functions or responsibilities in connection with either the award or execution of the project to which this contract pertains.

Further, the vendor acknowledges, under the pains and penalties of perjury, that he/she has not offered, paid, or solicited by way of any contribution or compensation, nor has he/she granted a gift, gratuity or other consideration either directly or indirectly to any officer, employee, or member of the governing body of the City of Pawtucket who exercises any functions or responsibilities in connection with either the award or execution of the project to which this project or contract pertains.

\_\_\_\_\_  
**SIGNATURE OF BIDDER/OFFEROR**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**TITLE**

\_\_\_\_\_  
**COMPANY**

**Title of RFP or BID:**  
\_\_\_\_\_

## **Census Data**

City of Pawtucket  
Subscriber Headcounts By Group  
City and School

City

Group	Name	Classic		HealthMate		BlueCHiP		WRI only
		I	F	I	F	I	F	I
1187	Munic			73	144			
M1187	Munic	0	0			0	1	
5349	Fire			30	98			
M5349	Fire					0	4	18
5384	Police			34	102			
M5384	Police							15
7112	PD Ret	4	5					
101821	FD Ret			4	16			
M01821	FD Ret	0	0			0	4	
8U493	PD Ret							
	pck 002			3	49			
	pck 004			3	13			
	pck 005			0	7			
M8U493	PD Ret	10	78					
8U494	Mun Ret							
	pck 002			9	25			
	pck 004			4	14			
M8U494	Mun Ret	2	3			0	1	
M8V435	FD Ret II	8	52					
8V435	pck 002			5	30			
	pck 003			0	10			
	pck 006			0	5			
	pck 007			0	3			
8W460	Prof/Tech			7	38			
1C053	Cl + Uncl			10	23			
<b>Totals</b>	<b>(931)</b>	<b>24</b>	<b>138</b>	<b>182</b>	<b>577</b>	<b>0</b>	<b>10</b>	<b>33</b>
1135-2	Plan 65	70						

School

Group	Name	Classic		HealthMate		BlueCHiP	
		I	F	I	F	I	F
150	Teachers			183	572		
M150	Teachers	50	93			3	6
3096	Non-cert			35	179		
M3096	Non-cert	10	13				
3H64	Ret	0	1				
101225	Admin	-	-	-	-	-	-
M01225	Admin	2	4				
1E337	Admin			6	22		
<b>Totals</b>	<b>(1177)</b>	<b>62</b>	<b>109</b>	<b>224</b>	<b>773</b>	<b>3</b>	<b>6</b>
7448-2	Plan 65	0					

## **Benefit Summaries**

**1187 Healthmate Coast to Coast  
Active Local 1012**

Office Visit	\$10.00
E.R. Visit	\$25.00
Deductible	None
Specialist	\$10.00, Allergist and Dermatologist \$25.00
Urgent Care	\$10.00
Prescriptions	\$5.00/\$10.00/\$30.00 Maint. Prescription 3 month supply for 1 month Co-Pay
Vision Rider	\$100.00 reimbursement per calendar year

**M1187 Blue Chip  
Active Local 1012**

Office Visit	\$10.00
E.R. Visit	\$25.00
Deductible	None
Specialist	\$0.00
Urgent Care	\$10.00
Prescriptions	20% of prescription
Vision Rider	\$100.00 reimbursement per calendar year

**5384 Healthmate Coast to Coast  
Active Police**

Office Visit	\$15.00
E.R. Visit	\$100.00
Deductible	None
Specialist	\$25.00,
Urgent Care	\$25.00
Prescriptions	\$7.00/\$15.00/\$40.00 Maint. Prescription 3 month supply for 2.5 month Co-Pay
Vision Rider	\$100.00 reimbursement per calendar year

**M5384 Blue Chip  
Active Police**

Office Visit	\$15.00
E.R. Visit	\$100.00
Deductible	None
Specialist	\$25.00,
Urgent Care	\$25.00
Prescriptions	\$5.00/\$15.00/\$40.00
	Maint. Prescription 3 month supply for 2 month Co-Pay

**101821 Healthmate Coast to Coast  
Retired Fire**

Office Visit	\$10.00
E.R. Visit	\$25.00
Deductible	None
Specialist	\$10.00, Allergist and Dermatologist \$15.00
Urgent Care	\$10.00
Prescriptions	\$5.00/\$10.00
Vision Rider	\$100.00 reimbursement per calendar year

**M01821 Blue Chip  
Retired Fire**

Office Visit	\$0.00
E.R. Visit	\$25.00
Deductible	None
Specialist	\$10.00, Allergist and Dermatologist \$25.00
Urgent Care	\$10.00
Prescriptions	20% of prescription

**8U494 Healthmate Coast to Coast  
Retired Municipal pck. 002**

Office Visit	\$10.00
E.R. Visit	\$25.00
Deductible	None
Specialist	\$10.00, Allergist and Dermatologist \$15.00
Urgent Care	\$10.00
Prescriptions	\$5.00/\$10.00/\$30.00
	Maint. Prescription 3 month supply for 1 month Co-Pay
Vision Rider	\$100.00 reimbursement per calendar year

**8U494 Healthmate Coast to Coast  
Retired Municipal pck. 004**

Office Visit	\$10.00
E.R. Visit	\$50.00
Deductible	None
Specialist	\$10.00, Allergist and Dermatologist \$15.00
Urgent Care	\$10.00
Prescriptions	\$5.00/\$10.00/\$30.00 Maint. Prescription 3 month supply for 1 month Co-Pay
Vision Rider	\$100.00 reimbursement per calendar year

**M8U494 Classic  
Retired Municipal**

Office Visit	\$0.00
E.R. Visit	\$50.00
Deductible	None
Specialist	\$0.00
Urgent Care	\$10.00
Prescriptions	20% of prescription

**8W460 Healthmate Coast to Coast  
Active Local 3960 & Teamsters**

Office Visit	\$10.00
E.R. Visit	\$50.00
Deductible	None
Specialist	\$10.00, Allergist and Dermatologist \$15.00
Urgent Care	\$10.00
Prescriptions	\$5.00/\$10.00/\$30.00 Maint. Prescription 3 month supply for 1 month Co-Pay
Vision Rider	\$100.00 reimbursement per calendar year

**1C053 Healthmate Coast to Coast  
Active Classified/Unclassified**

Office Visit	\$10.00
E.R. Visit	\$25.00
Deductible	None
Specialist	\$10.00, Allergist and Dermatologist \$15.00
Urgent Care	\$10.00
Prescriptions	\$5.00/\$10.00/\$30.00 Maint. Prescription 3 month supply for 1 month Co-Pay
Vision Rider	\$100.00 reimbursement per calendar year

**5349 Healthmate Coast to Coast  
Active Fire**

Office Visit	\$15.00
E.R. Visit	\$100.00
Deductible	None
Specialist	\$10.00, Allergist and Dermatologist \$15.00
Urgent Care	\$15.00
Prescriptions	\$7.00/\$25.00/\$40.00 Maint. Prescription 3 month supply for 2.5 month Co-Pay
Vision Rider	\$100.00 reimbursement per calendar year

**M5349 Blue Chip  
Active Fire**

Office Visit	\$0.00
E.R. Visit	\$50.00
Deductible	None
Specialist	\$0.00
Urgent Care	\$10.00
Prescriptions	20% of Prescription

**7112 Classic  
Retired Police**

Office Visit	\$0.00
E.R. Visit	\$0.00
Deductible	\$100.00/\$200.00 Major Medical with RX
Specialist	\$0.00
Urgent Care	\$0.00
Prescriptions	20% after deductible is satisfied

**8U493 Healthmate Coast to Coast  
Retired Police pck. 002**

Office Visit	\$10.00
E.R. Visit	\$25.00
Deductible	None
Specialist	\$10.00, Allergist and Dermatologist \$15.00
Urgent Care	\$10.00
Prescriptions	\$5.00/\$10.00/\$30.00 Maint. Prescription 3 month supply for 1 month Co-Pay
Vision Rider	\$100.00 reimbursement per calendar year

**8U493 Healthmate Coast to Coast  
Retired Police pck. 004**

Office Visit	\$10.00
E.R. Visit	\$50.00
Deductible	None
Specialist	\$10.00, Allergist and Dermatologist \$15.00
Urgent Care	\$10.00
Prescriptions	\$5.00/\$15.00/\$40.00 Maint. Prescription 3 month supply for 2 month Co-Pay
Vision Rider	\$100.00 reimbursement per calendar year

**8U493 Healthmate Coast to Coast  
Retired Police pck. 005**

Office Visit	\$15.00
E.R. Visit	\$100.00
Deductible	None
Specialist	\$10.00, Allergist and Dermatologist \$20.00
Urgent Care	\$15.00
Prescriptions	\$7.00/\$15.00/\$40.00 Maint. Prescription 3 month supply for 2 month Co-Pay
Vision Rider	\$100.00 reimbursement per calendar year

**M8U493 Classic  
Retired Police**

Office Visit	20%
E.R. Visit	\$0.00
Deductible	\$100.00/\$200.00 Major Medical without RX
Specialist	20%
Urgent Care	20%
Prescriptions	\$2.00
Vision Rider	\$100.00 reimbursement per calendar year

**8V435 Healthmate Coast to Coast  
Retired Fire pck. 002**

Office Visit	\$10.00
E.R. Visit	\$25.00
Deductible	None
Specialist	\$10.00, Allergist and Dermatologist \$15.00
Urgent Care	\$10.00
Prescriptions	\$5.00/\$10.00/\$30.00 Maint. Prescription 3 month supply for 1 month Co-Pay
Vision Rider	\$100.00 reimbursement per calendar year

**8V435 Healthmate Coast to Coast  
Retired Fire pck. 004**

Office Visit	\$10.00
E.R. Visit	\$50.00
Deductible	None
Specialist	\$10.00, Allergist and Dermatologist \$15.00
Urgent Care	\$10.00
Prescriptions	\$5.00/\$10.00/\$30.00 Maint. Prescription 3 month supply for 1 month Co-Pay
Vision Rider	\$100.00 reimbursement per calendar year

**8V435 Healthmate Coast to Coast  
Retired Fire pck. 006**

Office Visit	\$10.00
E.R. Visit	\$75.00
Deductible	None
Specialist	\$10.00, Allergist and Dermatologist \$20.00
Urgent Care	\$10.00
Prescriptions	\$5.00/\$10.00/\$30.00 Maint. Prescription 3 month supply for 2 month Co-Pay
Vision Rider	\$100.00 reimbursement per calendar year

**8V435 Healthmate Coast to Coast  
Retired Fire pck. 007**

Office Visit	\$15.00
E.R. Visit	\$100.00
Deductible	None
Specialist	\$25.00
Urgent Care	\$15.00
Prescriptions	\$7.00/\$25.00/\$40.00 Maint. Prescription 3 month supply for 2.5 month Co-Pay
Vision Rider	\$100.00 reimbursement per calendar year

**M8V435 Classic  
Retired Fire**

Office Visit	20%
E.R. Visit	0.00
Deductible	\$100.00/\$200.00 Major Medical without RX
Specialist	20%
Urgent Care	20%
Prescriptions	\$2.00
Vision Rider	\$100.00 reimbursement per calendar year

**Schools**  
**Teacher Healthmate Coast to Coast**  
**H 150**

Office Visit	\$15.00
E.R. Visit	\$100.00
Deductible	None
Specialist	\$25.00
Urgent Care	\$25.00
Prescriptions	\$5.00/\$15.00/\$30.00
Mail 90 Days	\$12.50/\$37.50/\$75.00
Vision Rider	\$100.00 for frames & lenses per calendar year

**Teacher Classic**  
**M 150**

Office Visit	\$0
E.R. Visit	\$25.00
Deductible	Major Medical without Rx: \$300.00/\$600.00, 80/20 %
Specialist	\$0
Urgent Care	\$10.00
Prescriptions	\$5.00/\$10.00
Mail 90 Days	\$10.00/\$20.00
Vision Rider	\$100.00 for frames & lenses per calendar year

**Non Certified Healthmate Coast to Coast**  
**3096**

Office Visit	\$10.00
E.R. Visit	\$25.00
Deductible	None
Specialist	\$10.00
Urgent Care	\$10.00
Prescriptions	\$5.00/\$10.00/\$30.00
Mail 90 Days	\$5.00/\$10.00/\$30.00
Vision Rider	\$100.00 for frames & lenses per calendar year

**Non Certified Classic  
M 3096**

Office Visit	\$0
E.R. Visit	\$0
Deductible	Major Medical without Rx: \$200.00/\$400.00, 80/20%
Specialist	\$0
Urgent Care	\$0
Prescriptions	\$2.00
Vision Rider	\$100.00 for frames & lenses per calendar year

**Administration Classic  
M 01225**

Office Visit	\$0
E.R. Visit	\$25.00
Deductible	Major Medical without Rx: \$200.00/\$400.00, 80/20%
Specialist	\$0
Urgent Care	\$0
Prescriptions	\$2.00
Vision Rider	\$100.00 for frames & lenses per calendar year

**Administration Healthmate Coast to Coast  
I E 337**

Office Visit	\$10.00
E.R. Visit	\$25.00
Deductible	None
Specialist	\$10.00
Urgent Care	\$10.00
Prescriptions	\$5.00/\$10.00/\$30.00
Vision Rider	\$100.00 for frames & lenses per calendar year

**United Healthcare Choice Plus**

Office Visit	\$10.00
E.R. Visit	\$50.00
Deductible	None
Specialist	\$10.00
Urgent Care	\$25.00
Prescriptions	\$7.00/\$15.00/\$30.00
Mail 90 days	\$14.00/\$30.00/\$60.00

City of PAWTUCKET, R.I.							
2013-2014							
Claimant	Member Date of Birth	Relationship	Diagnosis	Total Claims 7/12-6/13 Policy as of APR. 2013 \$250,000	Total Claims 7/11-6/12 Policy as of APR. 2013 \$250,000	Total Claims 7/10-6/11 Policy as of JUNE 2012 \$250,000 FINAL	Comments
1	07/30/33		585.6 Chronic renal failure & 383 mastoiditis, 284.1 Anemia				
2	10/01/43		327.23 Sleep apnea, 414.01 Coronary atherosclerosis, 427.31				
3	02/16/66	EE	462 Pharyngitis, 173.5 Skin cancer, trunk, V5811				(Connor) RETIRED 5/1/10 - "disenrolled 8/1/10"
4	03/28/58	SP	585.6 Chronic renal failure & 250.8 diabetes 996.62				
5	08/05/48		148.1 Malig. Neop. Sinus, 195.0 Head, face, 160.9				
6	09/29/50		164.3 Malig. Neop. Mediastinum, V5811				
7	01/06/03		288.0 Agranulocytosis, white blood cells				
8	07/30/47		431 Intracerebral hemorrhage				
9	10/16/48		174.9 Malig. Neop. Breast				
10	09/21/53		420.90 Acute Pericarditis				
11	07/01/47		172.9 Melanoma, skin				
12	07/01/39		518.81 Respiratory failure				
13	02/28/66		189.0 Malig. Neop. Kidney			\$129,513.72	
14	06/02/43		191.9 Malig. Neop. Brain				
15	05/13/22	EE	995.91 Sepsis, 574 Cholecystitis, 8.45 Clostridium				
16	04/05/56		174.9 Malig. Neop. Breast V5811				
17	11/13/54		722.83, 723.1, 722.10 Lumbar disc disorders				
18	02/07/62		141.9 141.0 Malig. Neop. Tongue, 038.9 Septicemia				
19	05/28/03	DEP	383.1 Chronic mastoiditis, 999.31 Infection				
20	02/13/31	EE	156.2 Malig. Neop. Vater, 211.3 benign, colon, 780.6		3/13 119,217	\$118,632.65	MEDICARE A PRIME
21	02/11/44		296.33 Depres disorder, 493.22 Asthma, 491.21 Bronchitis				
22	03/18/66	SP	296.32, 311 Depressive disorder, 303.91 Alcohol		\$168,200.16		
23	09/09/49	EE					
24	12/12/02	DEP					
25	09/18/52	SP					
26	01/29/79	SP					
27	06/01/50	SP					
28	04/24/48	EE					
29	10/6/1997	DEP					
30	1/1/1954	EE					
31	1/26/1952	EE					
32		DEP					
33		SP					
34	12/4/1945	EE					
35	9/4/1947	EE					Retired 7/1/10
36	3/13/1944	SP			\$139,878.79		
37	8/24/1947	SP					
38	2/17/1954	EE					
39	3/5/1949	EE					
40	9/15/1951	EE				\$129,016.39	to Retiree 5/1/11
41	3/26/1951	EE				\$126,417.27	
42	9/27/1952	DEP				\$144,385.48	
43	12/14/1952	SPS				\$128,306.03	
44		DEP				\$147,483.90	
45	5/12/1951	SPS			\$133,780.13	\$127,514.86	
46	12/1/1949	EE			\$799,626.55		DECEASED
47	9/29/2011	DEP	746.7 HYPOPLASTIC left heart syndrome, congenital anomaly		\$500,311.28		
48	3/30/1961	EE			\$135,701.07		
49	1/31/1966	EE			\$251,197.02		
50	11/1/1958	EE			\$159,065.58		
51	9/30/1946	EE		\$ 140,627.81	\$144,210.26		
52	6/18/1953	SPS			\$132,359.53		
53	11/23/1963	EE		\$ 741,692.59			
54	1/5/2013	DEP		\$ 141,461.29			
55	8/26/1958	SPS		\$ 247,985.51			

## City of Pawtucket 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 three family members must meet the individual amount per calendar year.
<b>Coinsurance</b>	0%	20%	
<b>Out-of-pocket maximum</b>	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.

*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>	\$0	\$10 plus 20% after deductible	Includes one physical exam and one gynecological exam per calendar year.
<b>Pediatric preventive care</b>	\$0	\$10 plus 20% after deductible	Pediatric preventive care is covered according to federal guidelines.
<b>Immunizations</b>	\$0	20% after deductible	Includes adult, pediatric, and travel immunizations.
<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>	\$10	\$10 plus 20% after deductible	
<b>Specialist</b>	\$10	\$10 plus 20% after deductible	Chiropractic visits are limited to 12 per calendar year. Routine eye exams are limited to 1 per calendar year. \$15 copayment for dermatologist and allergist visits.

### Outpatient Services

<b>Outpatient medical/surgical care</b> (facility and doctor services)	\$0	20% after deductible	
<b>Lab services, machine tests, and X-rays</b> (diagnostic)	\$0	20% after deductible	

### Inpatient Services

<b>Inpatient hospital services</b> - acute care - maternity	\$0	20% after deductible	Unlimited days at a general or specialty hospital. Up to 45 days per calendar year for physical rehabilitation.
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	Within the BlueCard® PPO Network you pay:	Outside of the BlueCard® PPO Network you pay:	Notes
<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>	\$10	\$10 plus 20% after deductible	
<b>Urgent Care or Emergency Care</b>			
<b>Urgent care center</b>	\$10	\$10 plus 20% after deductible	
<b>Emergency room care</b>	\$25	\$25	If emergency room visit results in hospital admission, \$25 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. Air and water ambulances are limited to a maximum of \$3,000 per occurrence.
<b>Additional Services</b>			
<b>Prescription drugs</b>	See prescription drug insert for details. Prescription drug copayments and coinsurance do not apply to your out-of-pocket maximum.		
<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.
<b>Home and hospice care</b>	\$0	20% after deductible	Includes physician, nurse, and home health aide visits.

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## 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 his or her individual deductible, the family deductible is satisfied.
- Once the out-of-network family deductible is met, the family only needs to pay coinsurance (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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09/11 CUST-10555

## Standard Plan 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	\$200 per individual	For family coverage: Up to a maximum of three family members must meet the individual amount per calendar year.
<b>Coinsurance</b>	0%	20%	
<b>Out-of-pocket maximum</b>	None	\$3,000 per individual	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.

*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>	\$10	\$10 plus 20% after deductible	Includes one physical exam and one gynecological exam per calendar year.
<b>Pediatric preventive care</b>	\$10	\$10 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>	\$10	\$10 plus 20% after deductible	
<b>Specialist</b>	\$10	\$10 plus 20% after deductible	Chiropractic visits are limited to 12 per calendar year. Routine eye exams are limited to 1 per calendar year. \$15 copayment for dermatologist and allergist visits.

### Outpatient Services

<b>Outpatient medical/surgical care</b> (facility and doctor services)	\$0	20% after deductible	
<b>Lab services, machine tests, and X-rays</b> (diagnostic)	\$0	20% after deductible	

### Inpatient Services

<b>Inpatient hospital services</b> - acute care - maternity	\$0	20% after deductible	Unlimited days at a general or specialty hospital. Up to 45 days per calendar year for physical rehabilitation.
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	Within the BlueCard® PPO Network you pay:	Outside of the BlueCard® PPO Network you pay:	Notes
<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>	\$10	\$10 plus 20% after deductible	
<b>Urgent Care or Emergency Care</b>			
<b>Urgent care center</b>	\$10	\$10 plus 20% after deductible	
<b>Emergency room care</b>	\$25	\$25	If emergency room visit results in hospital admission, \$25 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. Air and water ambulances are limited to a maximum of \$3,000 per occurrence.
<b>Additional Services</b>			
<b>Prescription drugs</b>	See prescription drug insert for details. Prescription drug copayments and coinsurance do not apply to your out-of-pocket maximum.		
<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.
<b>Home and hospice care</b>	\$0	20% after deductible	Includes physician, nurse, and home health aide visits.

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## 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 his or her individual deductible, the family deductible is satisfied.
- Once the out-of-network family deductible is met, the family only needs to pay coinsurance (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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## Pawtucket School Department BlueCHiP Plan – Benefit Summary

With BlueCHiP Coordinated Health Plan (BlueCHiP) from Blue Cross & Blue Shield of Rhode Island, you can take advantage of complete coverage for coordinated care, an extensive network of local providers, and a primary care physician (PCP) to guide you through the healthcare system.

### Network Coverage (Coordinated Care)

BlueCHiP allows you to choose a PCP from our extensive provider network. Your PCP will provide basic and preventive healthcare and refer you to specialty care when you need it. BlueCHiP also covers emergency and urgent care when you travel outside the service area.

### Out-of-network Coverage (Flex Plan)

If you have the Flex Plan as part of your BlueCHiP plan, you can receive care outside the network or without a referral from your PCP. (A separate deductible and coinsurance may apply.)

### Choosing a PCP

Selecting a PCP is easy:

1. Use our Provider Finder search tool on BCBSRI.com.
2. Call Customer Service with the physician's name and provider number.
3. Or, fill out and return the PCP selection/notification change form included in your welcome kit.

	When you coordinate care with your PCP you pay:	With the Flex Plan, after the deductible you pay:	Notes
<b>Deductible</b>	\$0	\$250 per individual \$500 per family	
<b>Coinsurance percentage</b>	N/A	20%	
<b>Out-of-pocket maximum</b>	N/A	\$3,000 per individual \$6,000 per family	Once you exceed this amount, we will pay up to our allowance for most covered services. The out-of-network deductible is included in the out-of-pocket maximum.
<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 that we send to you after processing your claim. You must pay the provider the total amount shown in the section labeled "Your Responsibility" in the explanation of benefits.</i>			
<b>Preventive Care</b>			
<b>Adult preventive care</b>	\$15	20% after deductible	Includes one physical exam and one gynecological exam per calendar year.
<b>Pediatric preventive care</b>	\$15	20% after deductible	
<b>Immunizations</b>	\$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.
<b>Lab services, machine tests, and X-rays</b>	\$0	20% after deductible	Pap smears, screening mammograms, and prostate-specific antigen (PSA) tests.
<b>Office Visits</b>			
<b>Primary care physician (PCP)</b>	\$15	20% after deductible	
<b>Specialist</b>	\$25	20% after deductible	Including but not limited to: 12 chiropractic visits per calendar year (Not covered by Flex) 1 routine eye exam per calendar year (Not covered by Flex) Prenatal visits covered in full after first office visit copay.

*continued*

	When you coordinate care with your PCP you pay:	With the Flex Plan, after the deductible you pay:	Notes
<b>Outpatient Services</b>			
<b>Outpatient medical/surgical care</b> (facility and doctor services)	\$0	20% after deductible	
<b>Diagnostic lab services, machine tests, and X-rays</b>	\$0	20% after deductible	
<b>Inpatient Services</b>			
<b>Inpatient hospital facilities:</b> – Acute care – Maternity – Mental healthcare – Chemical dependency	\$0	20% after deductible	Unlimited days at a general, specialty, or mental health hospital; Maximum of 45 days per calendar year for physical rehabilitation.
<b>Urgent Care or Emergency Care</b>			
<b>Urgent care center</b>	\$25	20% after deductible	
<b>Emergency room care</b>	\$100	\$100	If emergency room visit results in hospital admission, ER copayment is waived. You may be billed an additional specialist copayment if you are seen by a specialist in the ER.
<b>Ambulance services</b>	\$50	\$50	Coverage for medically necessary/emergency services. Air and water ambulance services are limited to a maximum of \$3,000 per occurrence.
<b>Additional Services</b>			
<b>Prescription drugs</b>	<i>See prescription drug insert for details. Prescription drug copayments and coinsurance do not apply to your out-of-pocket maximum.</i>		
<b>Physical/occupational therapy</b>	20%	Not covered	
<b>Durable medical equipment (DME)</b>	\$20	20% after deductible	Must be purchased from our participating DME vendor. Pharmacies are NOT participating in the DME network.
<b>Home and hospice care</b>	\$0	20% after deductible	Includes physician, nurse, and home health aide visits.

*This grid provides a general summary of your BlueCHIP 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) 274-3500 or 1-800-564-0888 (outside of Rhode Island). If you have any questions about receiving medical care, call your primary care physician.*

## Key terms

**Coinsurance:** The percentage of our allowance that you must pay for a covered healthcare service

**Copayment:** A fixed dollar amount you must pay for a covered healthcare service

**Deductible:** A fixed amount you have to pay for covered out-of-network 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

**Primary 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, including, but not limited to oncology, cardiology, ophthalmology, dermatology or allergies.



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10/09 BCHP-6462

## Standard Plan 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	\$200 per individual	For family coverage: Up to a maximum of three family members must meet the individual amount per calendar year.
<b>Coinsurance</b>	0%	20%	
<b>Out-of-pocket maximum</b>	None	\$3,000 per individual	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.

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### 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>	\$25	\$25 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

<b>Outpatient medical/surgical care</b> (facility and doctor services)	\$0	20% after deductible	
<b>Lab services, machine tests, and X-rays</b> (diagnostic)	\$0	20% after deductible	

### Inpatient Services

<b>Inpatient hospital services</b> - acute care - maternity	0%	20% after deductible	Unlimited days at a general or specialty hospital. Up to 45 days per calendar year for physical rehabilitation.
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	Within the BlueCard® PPO Network you pay:	Outside of the BlueCard® PPO Network you pay:	Notes
<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>	\$25	20% after deductible	
<b>Urgent Care or Emergency Care</b>			
<b>Urgent care center</b>	\$25	\$25 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. Air and water ambulances are limited to a maximum of \$3,000 per occurrence.
<b>Additional Services</b>			
<b>Prescription drugs</b>	See prescription drug insert for details. Prescription drug copayments and coinsurance do not apply to your out-of-pocket maximum.		
<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.
<b>Home and hospice care</b>	\$0	20% after deductible	Includes physician, nurse, and home health aide visits.

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## Key Terms

**Coinsurance:** The percentage of our allowance that you must pay for a covered healthcare service.

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**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 his or her individual deductible, the family deductible is satisfied.
- Once the out-of-network family deductible is met, the family only needs to pay coinsurance (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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08/10 HM-7619

## Standard Plan Benefit Summary

HealthMate Coast-to-Coast focuses on preventive care, setting the foundation for continued good health. Plus, you benefit from:

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- **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	\$200 per individual	For family coverage: Up to a maximum of three family members must meet the individual amount per calendar year.
<b>Coinsurance</b>	0%	20%	
<b>Out-of-pocket maximum</b>	None	\$3,000 per individual	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.

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### Preventive Care

<b>Adult preventive care</b>	\$10	\$10 plus 20% after deductible	Includes one physical exam and one gynecological exam per calendar year.
<b>Pediatric preventive care</b>	\$10	\$10 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>	\$10	\$10 plus 20% after deductible	
<b>Specialist</b>	\$10	\$10 plus 20% after deductible	Chiropractic visits are limited to 12 per calendar year. Routine eye exams are limited to 1 per calendar year. \$15 copayment for dermatologist and allergist visits.

### Outpatient Services

<b>Outpatient medical/surgical care</b> (facility and doctor services)	\$0	20% after deductible	
<b>Lab services, machine tests, and X-rays</b> (diagnostic)	\$0	20% after deductible	

### Inpatient Services

<b>Inpatient hospital services</b> - acute care - maternity	\$0	20% after deductible	Unlimited days at a general or specialty hospital. Up to 45 days per calendar year for physical rehabilitation.
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	Within the BlueCard® PPO Network you pay:	Outside of the BlueCard® PPO Network you pay:	Notes
<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>	\$10	\$10 plus 20% after deductible	
<b>Urgent Care or Emergency Care</b>			
<b>Urgent care center</b>	\$10	\$10 plus 20% after deductible	
<b>Emergency room care</b>	\$25	\$25	If emergency room visit results in hospital admission, \$25 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. Air and water ambulances are limited to a maximum of \$3,000 per occurrence.
<b>Additional Services</b>			
<b>Prescription drugs</b>	See prescription drug insert for details. Prescription drug copayments and coinsurance do not apply to your out-of-pocket maximum.		
<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.
<b>Home and hospice care</b>	\$0	20% after deductible	Includes physician, nurse, and home health aide visits.

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**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 his or her individual deductible, the family deductible is satisfied.
- Once the out-of-network family deductible is met, the family only needs to pay coinsurance (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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Your prescription drug plan divides all covered drugs into four different levels (tiers).

**Tier 1, Tier 2, and Tier 3** drugs are listed in the Preferred Drug List. **Tier 4** drugs are listed in the Specialty Drug List. Both lists can be found on [BCBSRI.com](http://BCBSRI.com).

		Copayment per 30-day supply	Mail Order 90-day supply
<b>Tier 1</b>	Low cost generic drugs	\$5	\$12.50
<b>Tier 2</b>	Higher cost generic and preferred brand name drugs	\$15	\$37.50
<b>Tier 3</b>	Non-preferred brand name drugs	\$30	\$75
<b>Tier 4</b>	Specialty drugs	\$30*	N/A

Prescribed over-the-counter aspirin, folic acid, iron supplements, and smoking cessation medications purchased at a retail pharmacy are covered at 100% according to federal guidelines.

*\*Infertility drugs, including oral and injectable drugs, are covered with a 20% coinsurance.*

## Filling Prescriptions

**Network retail pharmacies.** Our network includes approximately 64,000 retail pharmacies. Please visit [BCBSRI.com](http://BCBSRI.com) for our participating pharmacy directory.

**Mail order through CVS Caremark.** You can order up to a **90-day supply** of most drugs through the mail (excludes specialty drugs).

- You can access CVS Caremark by logging in to [BCBSRI.com](http://BCBSRI.com). Select "Pharmacy" on the left hand side of your member home page and follow the prompt from there.
- You can also call CVS Caremark at 1-866-329-3053 (TDD 1-800-231-4403).
- To request a mail order brochure, please contact BCBSRI Customer Service.

## About Specialty Drugs

Specialty drugs must be purchased at one of the participating specialty pharmacies listed below to receive the maximum benefit. You can receive up to a 30-day supply at a time.

**Caremark Specialty Pharmacy Services**  
1-866-278-6634

**Village Fertility Pharmacy**  
1-877-334-1610

You or your doctor may need to get prior authorization (pre-approval) for some specialty drugs before they will be covered.

## Using Out-of-network Pharmacies

**Tier 1, Tier 2, and Tier 3:** There is no coverage for non-participating retail and mail order pharmacies.

**Tier 4:** If you purchase a specialty drug at a non-participating specialty pharmacy, you must pay for it in full at the time of purchase. You will be reimbursed at 50% of our allowance for most specialty drugs. Specialty infertility drugs will be reimbursed at 80% of our allowance.

## Saving Money on Prescription Drugs

**Choose generic drugs when appropriate.** Generic drugs have the same active ingredients as their brand name equivalents, and are approved by the U.S. Food and Drug Administration (FDA). Ask your doctor if you can take a generic drug.

**Choose over-the-counter drugs whenever possible.** Over-the-counter drugs (OTCs) are medications that do not require a prescription. Most are less expensive than their prescription equivalents, but have the same active ingredients. Ask your doctor if an OTC drug is available for you.

**Choose a lower-cost drug within the same class when appropriate.** All drugs are grouped into classes, based on the medical conditions they treat. These drugs,

though, are not necessarily in the same tier under your prescription drug plan. If you are taking a high-cost drug, there may be a less expensive alternative drug that is in the same drug class. Ask your doctor if a lower-cost alternative is available.

**Half-tab program:** With your physician's approval, you can have certain prescriptions filled at double the strength, get half the amount of pills and only pay half the amount of your drug copayment. You will be provided a pill splitter with this voluntary program and will take a half-tablet dosage instead of a whole pill. Consult with your physician to see if this practice is safe for the medications and dosages prescribed to you.

If you have any questions related to your prescription drug program, please call us at the appropriate number below.

**Customer Service for BlueChiP plans:** (401) 274-3500 (within RI) or 1-800-564-0888 (outside of RI only)

**Customer Service for all other BCBSRI plans:** (401) 459-5000 (within RI) or 1-800-639-2227 (outside of RI only)

**Telecommunications Device for the Deaf (TDD):** 1-888-252-5051