

BlueCHiP Plan 10 – 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
Deductible	\$0	\$250 per individual \$500 per family	For family coverage: Up to a maximum of two family members must meet the individual amount per calendar year.
Coinsurance percentage	N/A	20%	
Out-of-pocket maximum	N/A	\$3,000 per individual \$6,000 per family	For family coverage: Up to a maximum of two 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. The out-of-network deductible is included in the 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 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.

Preventive Care

Adult preventive care	\$10	20% after deductible	Includes one physical exam and one gynecological exam per calendar year.
Pediatric preventive care	\$10	20% after deductible	
Immunizations	\$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.
Lab services, machine tests, and X-rays	\$0	20% after deductible	Pap smears, screening mammograms, and prostate-specific antigen (PSA) tests.

Office Visits

Primary care physician (PCP)	\$10	20% after deductible	
Specialist	\$10	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

	When you coordinate care with your PCP you pay:	With the Flex Plan, after the deductible you pay:	Notes
Outpatient Services			
Outpatient medical/surgical care (facility and doctor services)	\$0	20% after deductible	
Diagnostic lab services, machine tests, and X-rays	\$0	20% after deductible	
Inpatient Services			
Inpatient hospital facilities: – 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.
Urgent Care or Emergency Care			
Urgent care center	\$20	20% after deductible	
Emergency room care	\$25	\$25	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.
Ambulance services	\$50	\$50	Coverage for medically necessary/emergency services. Air and water ambulance services are limited to a maximum of \$3,000 per occurrence.
Additional Services			
Prescription drugs	<i>See prescription drug insert for details. Prescription drug copayments and coinsurance do not apply to your out-of-pocket maximum.</i>		
Physical/occupational therapy	20%	Not covered	
Durable medical equipment (DME)	20%	20% after deductible	Must be purchased from our participating DME vendor. Pharmacies are NOT participating in the DME network.
Home and hospice care	\$0	20% after deductible	Includes physician, nurse, and home health aide visits.

This grid provides a general summary of your 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, allergy or psychiatry.



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