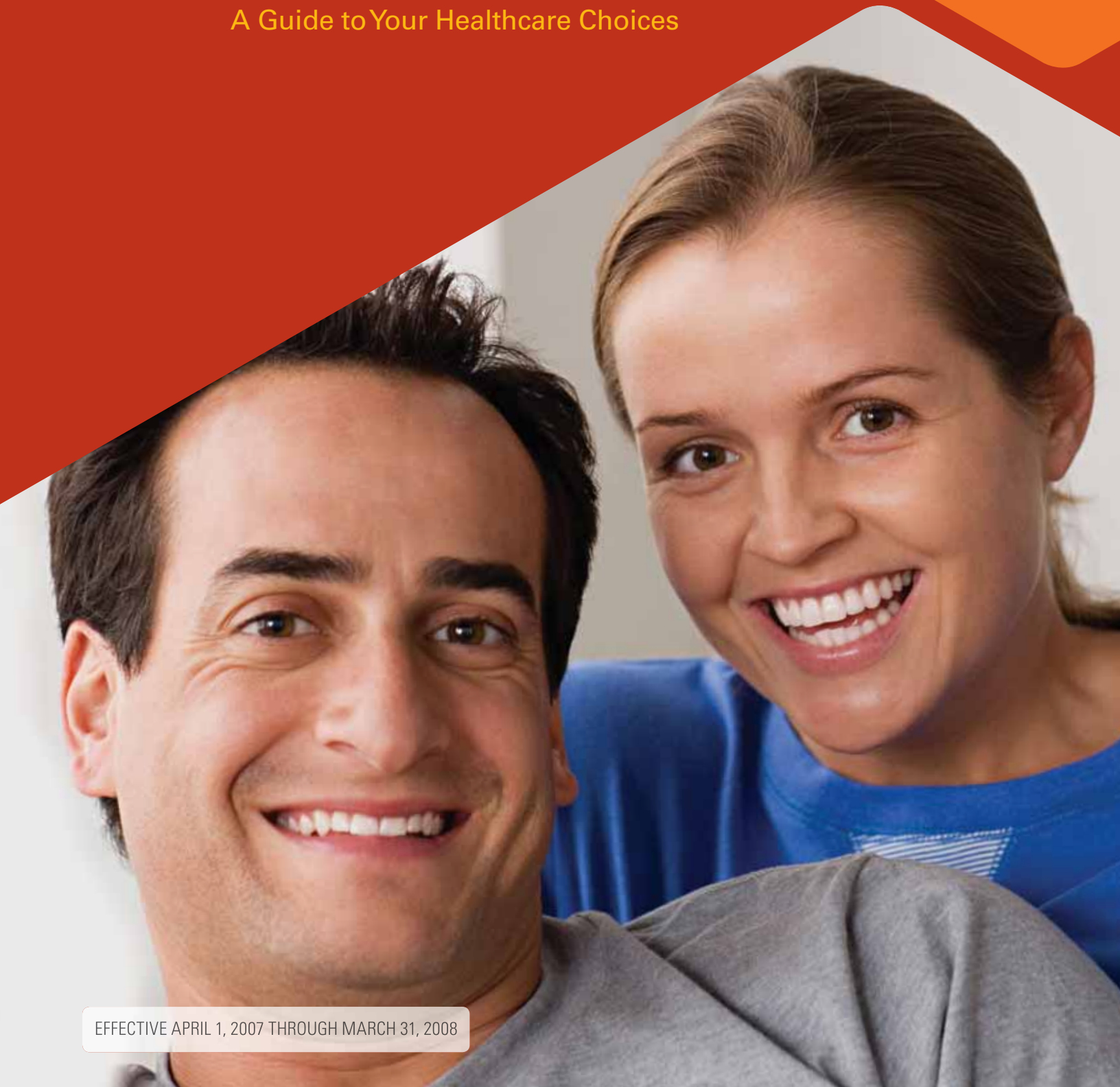
Blue Cross Blue Shield of Rhode Island

Plans for Individuals and Families

Direct to You

A Guide to Your Healthcare Choices



EFFECTIVE APRIL 1, 2007 THROUGH MARCH 31, 2008

With the cost of medical care rising every day, you don't want to go it alone. You want the ability to plan for your healthcare expenses and be protected from unforeseen costs—and that's what individual coverage from Blue Cross & Blue Shield of Rhode Island (BCBSRI) gives you. We've designed four health plans and a dental plan so that you can choose the plan that best fits your lifestyle.

With our plans, you'll have:

- No-hassle coverage for the healthcare services you need
- Financial protection if an unexpected illness or injury occurs
- Predictable monthly premiums

You get all this from a company you can trust. We've been providing Rhode Islanders with high-quality healthcare coverage since 1939, and Blue Cross and Blue Shield plans are accepted by more doctors and healthcare providers nationwide than any other health insurance carrier.

What is individual coverage?

When we say "individual coverage," we mean health or dental coverage that you buy directly from BCBSRI for you and your family. You have a contract with us, and we bill you directly. Not everyone can buy individual coverage. If you're eligible for coverage through an employer or through government programs such as Medicare, TriCare, or RIte Care, you aren't eligible for individual coverage. For details about how to become a member, please see page 14.

About Our Health Plans

With all of our health plans, you're protected at home in Rhode Island and wherever you travel. You'll enjoy advantages such as:

- Comprehensive coverage for medical care and prescription drugs
- Access to the extensive nationwide BlueCard® PPO network—the largest integrated provider network in the United States
- The option to visit non-network providers
- No referrals
- No claims to submit for in-network services
- No waiting period for pre-existing conditions

A Choice of Plans

When it comes to health coverage, different people have different needs. That's why we offer two types of health plans, each with two deductible options, for a choice of four plans. One plan may clearly be right for you, but if you're unsure, you can use our worksheet, included with this sales kit, to help you decide. At right is a summary of the plans we offer.

HealthMate Coast-to-Coast Direct. With these plans you'll only have to pay your copayment for office visits, urgent and emergency care, prescription drugs, and certain preventive care services. You're covered for most other healthcare services with coinsurance after you meet a deductible.

HealthMate for HSA Direct. You'll pay a larger share of your healthcare expenses with these plans, but you'll enjoy lower monthly premiums. You can use these plans with a health savings account (HSA) for a tax-free way to pay for medical expenses. These plans offer full coverage for certain preventive care services. After you pay the deductible, most office visits, prescription drugs, and other healthcare expenses are covered at 100 percent within the network.

A Choice of Healthcare Providers

Locally, you can visit thousands of doctors, as well as every hospital in Rhode Island. You'll also have access to the BlueCard PPO network, which is made up of the networks of Blue Cross and Blue Shield plans across the country. The BlueCard PPO network contains 740,000 doctors and 6,100 hospitals, including all 14 of the top hospitals in the country, as rated by "U.S. News & World Report." Our plans also give you the option to visit providers outside of our network.

Deductibles

Our plans work for you even while you are meeting the plan deductible. All of our health plans require you to meet a deductible each calendar year. This means you pay for your healthcare services yourself until you reach the deductible amount. But while you're working toward your deductible or paying coinsurance, you'll have the advantage of our negotiated discounts with providers—so you'll pay less than the provider would typically charge if you didn't have health coverage.

The Protection of Out-of-pocket Maximums

All of our plans limit the amount you must pay out of your own pocket in any given calendar year. The annual out-of-pocket maximum helps you plan ahead and manage your healthcare costs. This maximum also protects you from the potentially high costs of a catastrophic illness or injury.

Prescription Drug Coverage

All of our plans include coverage for prescription drugs. You'll have access to more than 50,000 pharmacies, including most major chain stores and independent pharmacies. You can also save yourself a trip to the pharmacy by using PrecisionRx, our convenient mail order service, to purchase medications you take on a regular basis.

More Than Just a Health Plan

You come to BCBSRI for the high-quality health coverage we're known for, but you get much more than that. We're here to support your health needs—whether it's with friendly help from a Customer Service representative, useful health information from our Web site, or guidance from one of our health management programs.

Customer Service

We're not just known for our extensive provider network and our hassle-free benefits. Our Customer Service representatives are available to help you by telephone, in person, or through a secure messaging feature on our Web site. If you decide to contact us by phone, your average wait will only be 15 seconds. Any way you contact us, you'll talk to someone who can help you, no matter what your question is.

Save Time. Improve Your Health. Use BCBSRI.com.

You'll find many more convenient, time-saving features on BCBSRI.com, plus hundreds of articles on health and wellness from Mayo Clinic Health Information®. You'll also have access to free wellness programs and tools. You'll need to register for a personal identification number (PIN) to use some of the secure, members-only features. Once you have your PIN, log on to explore!

Member Self-service

Managing your health information is easier than ever. Any time of day or night, you can:

- Get information about benefits, copayments, and deductible status.
- See medical and prescription drug claims filed in the last 24 months.
- Request a new member ID card.
- Change your address.
- Enroll in our mail order drug program, and request refills.
- Find a provider in our local or national network with our Provider Finder.

Wellness Tools and Programs

If you're one of the approximately 73 million Americans who go online in search of health information, you know that many Web sites offer health-related content—but not all of it is credible. We offer more than 800 articles from Mayo Clinic Health Information, one of the most trusted names in healthcare. You can also use our free tools and programs to set wellness goals and create plans to achieve them:

- A **Personal Health Record** lets you track medical information and check for potential drug interactions.
- A **Personal Health Assessment** helps you identify and take advantage of opportunities to improve your health.
- **Tracking tools** allow you to monitor physical activity, pregnancy, or a health condition.
- **Personalized programs** help you improve your health, including nutrition improvement, weight management, smoking cessation, stress management, and back care programs.

Additional Perks

- You can save money on a variety of health and wellness products and services, including safety products, Weight Watchers® programs, and more with your BCBSRI ID card!

Have questions?

One of our Individual Sales Representatives can help you choose a plan that's right for you. Call **(401) 351-BLUE (2583)** or **1-800-505-BLUE (2583)** today!

Health Management

We encourage our members with health conditions or chronic illnesses to be involved in their care. Through our disease management and case management programs, members are empowered to actively participate in managing health condition(s). By working together with healthcare professionals to better understand the benefits, services, and available resources, members can improve wellness and enhance the quality of life.

Disease Management Programs

With the help of our disease management programs, thousands of members each year learn how to maintain and improve their health. Free literature, educational classes, health tools, and preventive care reminders are offered through our programs and special events. The following programs are available:

- Asthma Management Program
- Coronary Artery Disease Program
- Diabetes Management Program
- Congestive Heart Failure Program
- Smoking Cessation Program

Case Management Program

Case managers assist members who are experiencing chronic, complex, or catastrophic health conditions. Our team consists of qualified case managers who are registered nurses, licensed social workers, and medical directors. They can:

- Work with doctors to develop and coordinate a personalized plan of care
- Provide education and support
- Identify benefits and resources

We encourage all of our members to consider how participating in one of our health management programs may help improve their health.

HealthMate Coast-to-Coast Direct

These plans are designed for members who want predictable copayments for commonly used services, plus coverage and protection for larger healthcare expenses. With both plans you have:

- Copayments for office visits, urgent care, and emergency care, and 100 percent coverage for certain preventive services.
- Prescription drug coverage without a deductible. (Coinsurance applies.)
- Comprehensive coverage for other services after you meet your deductible. (Coinsurance applies.)
- The advantage of our negotiated discounts (our allowance) with providers while you're working toward your deductible or paying coinsurance, which means you'll pay less than the provider would typically charge.
- Out-of-pocket maximums for protection against catastrophic expenses.

Calendar Year Deductible

Each calendar year, you must pay the cost of certain services until you reach your deductible. You must meet a separate deductible for in-network and out-of-network services. The family in-network and out-of-network deductibles work in the following way:

- Each family member pays for services up to our allowance until two family members separately meet the individual deductible.
- Once one family member meets the individual deductible, he or she only needs to pay coinsurance for covered services during the rest of the calendar year.
- The rest of the family members will continue to pay for services (up to our allowance) until a second family member reaches the individual deductible. At that time, the family deductible is met.
- All family members then only pay applicable coinsurance, up to the out-of-pocket maximum.

You have a choice of two deductibles, depending on your needs:

1. **Plan 400/800**
   $400 individual/$800 family deductible and 10 percent coinsurance

   Out-of-pocket maximum of $2,500 for individual; $5,000 for family

2. **Plan 2000/4000**
   $2,000 individual/$4,000 family deductible and 20 percent coinsurance

   Out-of-pocket maximum of $3,000 for individual; $6,000 for family

Remember, plans with higher deductibles and coinsurance also have lower premiums.

Out-of-pocket Maximum

The out-of-pocket maximum helps you budget for your healthcare expenses and protects you against especially large costs if you experience a major illness or injury. It does this by limiting the amount of coinsurance you must pay in a calendar year. (Please note: The deductible is not counted toward the out-of-pocket maximum.)

The family out-of-pocket maximum works the same way as the family deductible:

- Each member of the family pays his or her coinsurance until two individuals separately meet the individual out-of-pocket maximum.
- Once one family member reaches the individual out-of-pocket maximum, he or she is covered at 100 percent.
- The rest of the family continues to pay their coinsurance for services until a second member of the family reaches the individual out-of-pocket maximum.
- Once a second member reaches the individual maximum, all remaining family members are covered at 100 percent.

Out-of-network Coverage

You have the freedom to visit any provider outside our network—the choice is yours. Please note that you will be required to pay a higher percentage of coinsurance. You are covered only up to our allowance for out-of-network services, and you may be billed for the difference between our allowance and the provider's charges. You get the most from your coverage when you go to providers within our extensive network.

Prescription Drug Coverage

You can have your prescriptions filled at any of our participating pharmacies, or through our mail order service. You'll be responsible only for your coinsurance for each prescription you have filled. (The deductible does not apply.) Your coinsurance will be based on the lower of: our allowance (how much we will pay for a certain drug) or the retail cost of the drug.

Coinsurance is calculated based on the following structure:

- **First tier** – generic drugs. You pay 20 percent of the cost of these drugs.
- **Second tier** – preferred brand name drugs. You pay 25 percent of the cost of these drugs.
- **Third tier** – brand name drugs. You pay 50 percent of the cost of these drugs. These drugs may have generic or preferred brand name alternatives, so you may want to ask your doctor if another medication can treat your medical condition.

To find out which drugs are in each tier, you can refer to our preferred drug list (also called a formulary). Our preferred drug list is available on BCBSRI.com or by calling Customer Service.

Here's an example of how the deductible would work for a family of three enrolled in HealthMate Coast-to-Coast Direct Plan 400/800 when using in-network services:

- Sue has a medical procedure that costs $400, so her deductible is met. She will only have to pay 10 percent coinsurance for in-network healthcare services for the rest of the year, up to the out-of-pocket maximum.
- Later that year, her husband Richard has X-rays and lab work totaling $200, and her daughter Jane has a procedure that costs $200. Their expenses cannot be combined to meet the second individual deductible.
- Then Richard has an additional $200 worth of services and meets his individual deductible. Since both Sue and Richard have met their individual deductibles, the family deductible is met. Now services for the whole family are covered after the applicable coinsurance.
- Once the family deductible is met, the $200 claim for Jane's procedure is processed again, and this time only the coinsurance is applied. The family is reimbursed for any money they paid above the coinsurance.

HealthMate Coast-to-Coast Direct

	PLAN 400/800		PLAN 2000/4000	
	Network Provider You Pay	Non-network Provider You Pay	Network Provider You Pay	Non-network Provider You Pay
Deductible (Per Calendar Year) Deductible applies to inpatient and outpatient hospital services, physical therapy, occupational therapy, speech therapy, lab tests and X-rays, durable medical equipment, and ambulance for all network and non-network provider services separately. *For Family Plans:* Two family members must separately meet the individual deductible.	$400 per individual $800 per family	$400 per individual $800 per family	$2,000 per individual $4,000 per family	$2,000 per individual $4,000 per family
Coinsurance	10% after deductible	40% after deductible	20% after deductible	40% after deductible
Maximum Out-of-pocket Expense (Per Calendar Year) Applies to network and non-network provider services separately. The deductible, infertility treatment coinsurance, flat dollar copayments, and prescription drug coinsurance do NOT apply to the annual out-of-pocket maximum; therefore, the benefit is not increased to 100% for these services when the out-of-pocket maximum is met. *For Family Plans:* Two family members must separately meet the individual out-of-pocket maximum.	$2,500 per individual $5,000 per family	$2,500 per individual $5,000 per family	$3,000 per individual $6,000 per family	$5,000 per individual $10,000 per family

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HealthMate Coast-to-Coast Direct

	PLAN 400/800		PLAN 2000/4000	
	Network Provider You Pay	Non-network Provider You Pay	Network Provider You Pay	Non-network Provider You Pay
Outpatient Services				
Preventive Services: adult and pediatric immunizations, Pap smears, mammogram screenings, prostate-specific antigen tests	$0	40% coinsurance after deductible	$0	40% coinsurance after deductible
Personal Physician Office Visits	$20 copayment per visit*	40% coinsurance plus $20 copayment per visit after deductible	$20 copayment per visit*	40% coinsurance plus $20 copayment per visit after deductible
Specialist Office Visits, including but not limited to: • 30 mental health and substance abuse visits per calendar year • 12 chiropractic visits per calendar year • 1 routine eye exam per calendar year	$40 copayment per visit*	40% coinsurance plus $40 copayment per visit after deductible	$40 copayment per visit*	40% coinsurance plus $40 copayment per visit after deductible
Urgent Care Center	$75 copayment per visit*	$75 copayment per visit*	$75 copayment per visit*	$75 copayment per visit*
Emergency Room	$200 copayment per visit*	$200 copayment per visit*	$200 copayment per visit*	$200 copayment per visit*
Outpatient Hospital Services	10% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Lab Tests and X-rays • Preauthorization is recommended for MRIs, MRA, CAT Scans, PET Scans, nuclear cardiac imaging	10% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Inpatient Services				
Inpatient Hospital Services, Inpatient Hospital Facility, Mental Healthcare, and Chemical Dependency: • Unlimited days at a general or mental health hospital • Up to 45 days at a physical rehabilitation hospital • Preauthorization is recommended	10% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Other Services				
Ambulance	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Physical and Occupational Therapy	10% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Durable Medical Equipment	10% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Prescription Drugs				
Retail Pharmacy and Mail Order • Preauthorization is required for certain drugs	20% for generic drugs* 25% for preferred brand* 50% for non-preferred brand*	Not covered	20% for generic drugs* 25% for preferred brand* 50% for non-preferred brand*	Not covered

* *Deductible does not apply.*

This brochure provides a general summary of our HealthMate for Coast-to-Coast Direct plans. It is not a contract. For details about coverage, including any limits and exclusions not noted here, call our Customer Service Department at (401) 459-5000 or 1-800-639-2227 or refer to the subscriber agreement.

HealthMate for HSA Direct

These high-deductible health plans are for people who are willing to take additional responsibility for their healthcare expenses in exchange for lower premiums. You can use either of these plans with a health savings account to help manage your healthcare expenses.

When you visit providers in our extensive network, you have:

- One hundred percent coverage for the following preventive services before you reach your deductible:
  - Well visits for children and adults
  - Immunizations for children and adults
  - Pap smears
  - Mammogram screenings
  - Prostate-specific antigen (PSA) screenings
- One hundred percent coverage for most services after you meet the deductible each calendar year
- The advantage of our negotiated discounts (our allowance) with providers while you're working toward your deductible or paying coinsurance, which means you'll pay less than the provider would typically charge

You have a choice of two deductibles, depending on your needs:

1. **Plan 3000/6000** – $3,000 individual/$6,000 family deductible
   100 percent in-network coverage after you meet your deductible
2. **Plan 5000/10000** – $5,000 individual/$10,000 family deductible
   100 percent in-network coverage after you meet your deductible

Remember, plans with higher deductibles also have lower premiums.

What is an HSA?

An HSA is a tax-favored account you can set up just to pay for current and future medical expenses. It is similar to an IRA account with one major difference: you can use the funds at any time to pay for qualified medical expenses.

HealthMate for HSA Direct

	PLAN 3000/6000		PLAN 5000/10000	
	Network Provider You Pay	Non-network Provider You Pay	Network Provider You Pay	Non-network Provider You Pay
Deductible (Per Calendar Year) Applies to network and non-network provider services separately. *For Family Plans:* To calculate whether you have met your family deductible, add the amount of covered healthcare expenses applied to the deductible for all eligible family members.	$3,000 per individual $6,000 per family	$3,000 per individual $6,000 per family	$5,000 per individual $10,000 per family	$5,000 per individual $10,000 per family
Coinsurance	0% after deductible	40% after deductible	0% after deductible	40% after deductible
Maximum Out-of-Pocket Expense (Per Calendar Year) The deductible, infertility treatment coinsurance, flat dollar copayments, and prescription drug coinsurance do NOT apply to the annual out-of-pocket maximum; therefore, the benefit is not increased to 100%. Applies to network and non-network provider services separately. *For Family Plans:* Two family members must separately meet the individual out-of-pocket maximum.	N/A	$6,000 per individual plan $12,000 per family plan	N/A	$10,000 per individual plan $20,000 per family plan
Outpatient Services				
Preventive Services: Adult and pediatric well visits and immunizations, Pap smears, mammogram screenings, and prostate-specific antigen screenings	$0 Deductible does not apply.	40% coinsurance Deductible does not apply.	$0 Deductible does not apply.	40% coinsurance Deductible does not apply.

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	HealthMate for HSA Direct			
	PLAN 3000/6000		**PLAN 5000/10000**	
	Network Provider You Pay	Non-network Provider You Pay	Network Provider You Pay	Non-network Provider You Pay
Outpatient Services *(continued)*				
Personal Physician Office Visits	0% after deductible	40% coinsurance after deductible	0% after deductible	40% coinsurance after deductible
Specialist Office Visits, including but not limited to: • 30 mental health and substance abuse visits per calendar year • 12 chiropractic visits per calendar year • 1 routine eye exam per calendar year				
Urgent Care Center				
Emergency Room				
Outpatient Hospital Services				
Lab Tests and X-rays • Preauthorization is recommended for MRIs, MRA, CAT Scans, PET Scans, nuclear cardiac imaging				
Inpatient Services				
Inpatient Hospital Services, Inpatient Hospital Facility, Inpatient Mental Healthcare, and Inpatient Chemical Dependency: • Unlimited days at a general or mental health hospital • Up to 45 days at a physical rehabilitation hospital • Preauthorization is recommended	0% after deductible	40% coinsurance after deductible	0% after deductible	40% coinsurance after deductible
Other Services				
Ambulance	0% after deductible	40% coinsurance after deductible	0% after deductible	40% coinsurance after deductible
Physical and Occupational Therapy				
Durable Medical Equipment				
Prescription Drugs				
Retail Pharmacy and Mail Order	0% after deductible	Not covered	0% after deductible	Not covered

Calendar Year Deductible

Each calendar year, you must pay the cost of certain services until you reach your deductible. You must meet a separate deductible for in-network and out-of-network services. The family in-network and out-of-network deductibles work in the following way:

- Each family member pays for covered healthcare services up to our allowance until the total amount paid by any one or all family members equals the family deductible.
- Once the in-network deductible is met, all in-network services are covered at 100 percent.
- Once the out-of-network deductible is met, the family only needs to pay coinsurance up to the out-of-pocket maximum.

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IMPORTANT NOTE ABOUT MEDICARE: The drug coverage provided under the HealthMate for HSA Direct plans is NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay. As a result, HealthMate for HSA Direct is considered "non-creditable coverage" by Medicare. This means that the coverage is NOT at least as good as Medicare coverage. This is important: People who have HealthMate for HSA Direct would receive more assistance with drug costs by enrolling in a Medicare prescription drug plan. If you have questions, review your "Medicare & You" handbook from Medicare, visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Here's an example of how the deductible would work for a family of three enrolled in HealthMate for HSA Plan 3000/6000 when using in-network services:

- Sue has a surgical procedure that costs $2,800.
- Her husband Richard goes to see his doctor several times, for a total of $500.
- Her daughter Jane has a sports injury, and her medical bills total $2,700.
- Together, they've reached their deductible amount of $6,000. They're now covered at 100 percent unless they use out-of-network services, which require a separate deductible.

Prescription Drug Coverage

You can have your prescriptions filled at any of our participating pharmacies, or through our mail order service. You pay for covered drugs until you have met your deductible. The amount you pay will be based on the lower of our allowance or the retail cost of the drug. Once your deductible is met, you are covered at 100 percent within the network. Pharmacy costs apply to your annual deductible, along with your medical expenses.

Out-of-network Coverage

You also have the freedom to visit any provider outside our network—the choice is yours. Please note that you will be required to pay coinsurance for out-of-network services up to the out-of-pocket maximum. You are covered only up to our allowance, and you may be billed for the difference between our allowance and the provider's charges. You get the most from your coverage when you go to providers within our extensive network.

Health Savings Accounts

With HealthMate for HSA Direct plans, you may have the option to open a health savings account (HSA). This is a tax-favored account set up just for the purpose of paying for current and future medical expenses. An HSA is not required with HealthMate for HSA Direct—the choice is yours.

HealthMate for HSA and Health Savings Accounts[1]

HealthMate for HSA Direct is a high-deductible health plan (HDHP) that meets the requirements of the Internal Revenue Service (IRS) for use with a health savings account (HSA). Opening an HSA is an option available if you purchase HealthMate for HSA Direct, but it is not a requirement.

How an HSA Works

For each month that you are enrolled in an HSA-compatible HDHP, such as HealthMate for HSA Direct, you can put money into an HSA. You can deposit up to the annual maximum amount allowable under IRS guidelines for individuals and families. The government adjusts the maximum amount each year. People between the ages of 55 and 65 can make additional "catch-up" contributions. Please refer to IRS Publication 969 for these specific contribution amounts.

Money you put into your HSA can be used as follows:

- You can withdraw money to pay for eligible medical expenses. The IRS publishes a list of allowable expenses. In general, this list includes but is not limited to: doctors' office visits, hospital care, dental care, vision care, prescription drugs, over-the-counter medications, copayments, deductibles, and coinsurance.
- You can spend money out of your HSA for non-medical expenses. However, you'll have to pay income tax and a 10-percent penalty for a non-medical withdrawal before you reach age 65.
- You can leave unused money in your HSA account from one year to the next. You may use your HSA money to pay qualified expenses that happened after the HSA was set up.
- Anyone can contribute to an HSA as long as the owner of the account is enrolled in an HDHP. Total contributions from all sources are limited to the annual maximum.

Tax Benefits of an HSA

An HSA is different from a traditional savings account. The biggest difference is that it can help you save on taxes in the following ways:

- You can deduct the amount of your HSA contributions from your total income for federal income tax purposes.
- You can withdraw money tax-free from an HSA to pay for qualified medical expenses.
- All interest earnings on HSAs are tax-free.

Qualifications for an HSA

To establish an HSA, you must meet the following requirements:

- You must be enrolled in an HDHP that meets IRS requirements, such as HealthMate for HSA Direct.
- You cannot be covered by another medical plan that is not an HDHP. (For example, you cannot be a dependent on anyone else's plan, except for vision or dental coverage.)
- You cannot be enrolled in Medicare.
- You cannot be claimed as a dependent on another person's tax return.

Please note: *You cannot open an HSA prior to the set up of your HDHP. For example, if you are enrolling in an HDHP on June 15 and your coverage is effective June 1, you are only eligible to open an HSA after June 15.*

Thinking About Opening an HSA?

As a BCBSRI member, you can enjoy the convenience of our arrangements with Wells Fargo Health Benefit Services (Wells Fargo) or Blue Healthcare Bank, our newest option, for your choice of HSA administrator.

With both HSA administrators, you can enjoy:

- Instant online account access
- Convenient payment and reimbursement
- Investment options

Blue Healthcare Bank

Blue Healthcare Bank is a financial services company that was established by the Blue Cross and Blue Shield Association and founded in 2006. It is wholly owned by 33 independent Blue Cross Blue Shield plans and provides exclusive support to participating Blues companies and their members enrolled in health-related consumer spending accounts.

Blue Healthcare Bank offers access to debit card services, systems processing, brokerage services and investment options, as well as an FDIC-insured savings account.

To learn more about Blue Healthcare Bank, please visit www.bluehealthcarebank.com/members or call **1-800-663-BLUE.**

Wells Fargo Health Benefit Services

With more than 27 million customers, Wells Fargo is one of the largest, strongest, and most highly regarded financial services companies in the nation. It has been in business for more than 150 years and has offered healthcare consumer spending accounts since 1987.

Wells Fargo has the highest possible credit rating of "Aaa (Excellent)" from Moody's Investor Service. Wells Fargo offers competitive administrative fees for its consumer spending accounts.

To learn more about Wells Fargo, please visit www.wfhbs.com/bcbsri or call **1-866-449-9912.**

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[1] *This section is intended to convey general information only and does not constitute tax or legal advice. Consult your attorney or tax advisor for advice on whether an HSA is right for you. The HSA is not an insurance product and is not administered by BCBSRI. Please contact your selected HSA custodian or trustee for information about your HSA.*

For more information on HSAs, please visit the IRS Web site at www.IRS.gov/formspubs/index.html. Helpful IRS publications include Publication 969, which describes various types of consumer spending accounts, and Publication 502, which describes qualified medical and dental expenses.

Blue Cross Dental Direct

Good dental care is essential for your overall good health. That's why Blue Cross Dental Direct focuses on preventive care to help you stay healthy. We offer comprehensive coverage and competitive rates for individual, two-person, and family plans. And our extensive network of dentists gives you access to the best care in your area. Here's what you'll receive with Blue Cross Dental Direct:

- Preventive care coverage, including routine cleanings, dental examinations, and X-rays
- Access to more than 700 participating dentists in Rhode Island as well as nearby Massachusetts and Connecticut
- The option to visit non-network providers
- No referrals
- No claims to submit for in-network services

Remember, you may purchase Blue Cross Dental Direct to round out your health coverage, or you can purchase dental coverage alone.

Waiting Period

A 12-month waiting period applies to all major restorative services. This means that your policy must be in effect for 12 months before you can receive coverage for these services.

Please note: *If you decide to cancel your policy, you must wait at least 12 months before you can reapply, and the 12-month waiting period will be reinstated.*

Covered Dental Services at a Glance

All services are covered up to a $1,000 calendar year maximum per member

Basic Preventive/Diagnostic Services		
Exams	**100%**	One initial or periodic examination per calendar year.
Cleanings	**100%**	Two cleanings per calendar year. One fluoride treatment per calendar year for eligible dependents to age 19 is also covered.
X-rays	**100%**	Bitewing X-rays – One set per calendar year. Full Mouth Set – One set per 60 months; Individual X-rays – as needed.
Minor Restorative Services		
Sealants	**80%**	One treatment every three years to unfilled/undecayed permanent molars for dependents aged 6-13.
Space Maintainers	**80%**	When not made of cast precious metals.
Fillings	**80%**	Amalgam and composite fillings are covered as needed. If material other than amalgam is used as a filling on posterior teeth, you are responsible for paying any difference between our allowance for amalgam fillings and the dentist's charge. Other restorative services covered include recementing of crowns or inlays.
Simple Extractions	**80%**	Removal of an erupted tooth not requiring surgery.
Biopsies	**80%**	Limited to the biopsy and examination of hard or soft oral tissue.
Minor Treatment for Acute Dental Pain	**80%**	Minor treatment to relieve pain.
Denture Repairs	**80%**	Covers services to repair broken dentures, including replacement of teeth, and reattachment or replacement of clasps or facings. Rebase or reline of full or partial dentures involving laboratory procedures is limited to once every five (5) years.
Root Canal Therapy	**80%**	Covers root canal therapy procedures, including pulpotomy, for all permanent teeth. Final restoration excluded.
Oral Surgery	**80%**	Includes surgical extractions and other eligible oral surgical procedures not covered under any medical or surgical insurance plan.
Non-surgical Periodontics	**80%**	Covers non-surgical procedures for the treatment of tissues supporting the teeth. Preauthorization is recommended for all periodontal services.
Major Restorative Services		
Crowns and Inlays	**50%**	Includes crowns, inlays, and onlays that are not part of a bridge. Replacement of an existing crown is covered only if more than five (5) years has elapsed since last placement. Preauthorization is recommended for all crowns and inlays.
Surgical Periodontics	**50%**	Covers procedures, including surgery, for the treatment of tissues supporting the teeth. Preauthorization is recommended for all periodontal services.

Dependents: Covered at same level as subscriber; includes spouse and unmarried, dependent children to January 1 following their 19th birthday.

Note: This dental plan does not cover any services for or related to temporomandibular joint dysfunction (TMJ).
You can visit non-participating dentists, and we will pay for covered services up to our allowance, minus any deductibles and/or coinsurance amounts.

How to Become a Member

To become a member of one of our individual plans, just follow the steps below. One of our Individual Sales Representatives can answer any questions you may have along the way. Just call **(401) 351-BLUE (2583)** or **1-800-505-BLUE (2583)**.

Step 1:

Determine if You Are Eligible

You can apply for individual coverage if you are a Rhode Island resident and you don't have other options for medical and/or dental coverage.

You cannot apply if you are eligible to get coverage in any of the following ways (even if you're not actually enrolled in these plans):

- Medicare, TriCare, or other federal programs
- RIte Care or other state programs
- Employer-sponsored group coverage or similar coverage—even if your employer does not pay any of the premium or your share of the premium is more expensive than our individual coverage.

Please note: *If you are self-employed, you may also be eligible for coverage as a small employer.*

For Blue Cross Dental Direct: You can apply for dental coverage even if you have health coverage through an employer. However, you cannot apply if you are eligible for employer- or government-sponsored dental coverage.

Dependent Eligibility

You and your dependents can enjoy the same level of coverage. This includes your spouse and any unmarried dependent children to age 19. In addition, student dependents are covered to age 25 under our medical plans.

Step 2:

Determine When You Qualify for Coverage

There are several ways to qualify for coverage. The most common ways are: if you are eligible under the Health Insurance Portability and Accountability Act (HIPAA), if you apply during our annual open enrollment, if you have lost eligibility for a state Medicaid or a military plan, or if you are converting from group coverage. You can also qualify if you pass our medical underwriting process.

To go through our medical underwriting process, you will need to fill out the medical questionnaire on pages 3 and 4 of our application. Your application will be reviewed to determine if you are eligible for health coverage.

Eligibility Under HIPAA

Under HIPAA, you are guaranteed coverage at our basic rate without a medical review if:

- You meet the eligibility guidelines listed in Step 1;
- You supply us with a certificate of creditable (acceptable) coverage that ended less than 63 days ago and was in force for 12 continuous months, or was in force for 18 months with no breaks of more than 63 days; and
- Generally coverage can be effective as of the date your previous coverage terminated.

Open Enrollment

HealthMate Coast-to-Coast Direct or **HealthMate for HSA Direct:** If you are not eligible for guaranteed coverage under HIPAA or you did not pass our medical underwriting review, you can apply during our annual open enrollment period. At that time, you are guaranteed coverage at our basic rate. Our open enrollment is held from August 15 through September 15 of each year. Coverage begins on October 1.

Blue Cross Dental Direct: Open enrollment for Blue Cross Dental is held quarterly. Depending on when you apply, coverage begins on January 1, April 1, July 1, or October 1.

Step 3:

Determine if You Are Eligible for a Lower Rate

If you are eligible, you will automatically receive our basic rate, but you may be eligible for a lower rate in the following ways:

- Our **preferred rate** is a discounted rate based on your health status, age, and gender. You must answer medical questions to apply for the preferred rate. If you qualify, your rate will increase every five years as you get older. To apply for the preferred rate, please fill out pages 3 and 4 of the application.
- Our **Premium Assistance Program** provides help with premiums for people who qualify. You could save up to $134 on each month's health plan premium bill. For more information on this program, please review the enclosed Premium Assistance Program brochure. To apply, please fill out the Premium Assistance Application and submit it along with your completed Health and Dental Application.

Please note: *You can apply for both programs. If you apply for both, we'll review your applications and send you a letter regarding your eligibility.*

Step 4:

Fill Out an Application

To apply for coverage, you will need to fill out the Health and Dental Application for yourself, and include each family member to be covered in the section on dependents. If you are interested in applying for our preferred rate, please complete the medical questionnaire on pages 3 and 4. Don't forget to sign your application on both pages 2 and 4, even if you are not applying through our medical underwriting process.

Return your completed, signed application(s) and a copy of your certificate of creditable coverage (if applicable) to:

Blue Cross & Blue Shield of Rhode Island
Individual Sales Department
444 Westminster Street
Providence, RI 02903

Glossary

Allowance
The maximum amount we will pay to a network provider or the maximum amount we will pay to you directly for treatment by a non-network provider for a covered healthcare service. Our allowance for a covered healthcare service may include payment for other related services.

BlueCard® PPO Network
The BlueCard PPO network is comprised of the local PPO networks of Blue Cross and Blue Shield plans across the country. Nationally, this network offers access to more than 6,100 hospitals and approximately 740,000 physicians. The BlueCard system allows you to receive care from any provider in one of these local networks and receive maximum benefits for eligible services.

Coinsurance
The percentage of our allowance that you must pay for covered healthcare services.

Copayment
A flat-dollar amount that you must pay per service for covered healthcare services.

Deductible
The amount of covered healthcare expenses that you must pay per calendar year before we provide benefits. The network provider and non-network provider calendar year deductibles accumulate separately. Covered healthcare expenses are calculated based on our allowance, not on actual charges.

Health Savings Account (HSA)
A tax-favored savings account set up just for the purpose of paying unreimbursed, qualified medical expenses. An HSA is similar to an individual retirement account (IRA) with one major difference: you can use the money at any time to pay for qualified medical expenses.

High-Deductible Health Plan (HDHP)
A health insurance plan with specific rules for coverage set by the IRS that meets the requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to have a specified deductible. A qualifying HDHP has a minimum annual deductible and out-of-pocket maximum for individuals and families, a combined medical and pharmaceutical deductible, and first-dollar coverage for preventive services. It also enables consumers to enroll in a health savings account (HSA).

Network Provider
A provider that has entered into an agreement with BCBSRI or a Blue Cross or Blue Shield plan in another state.

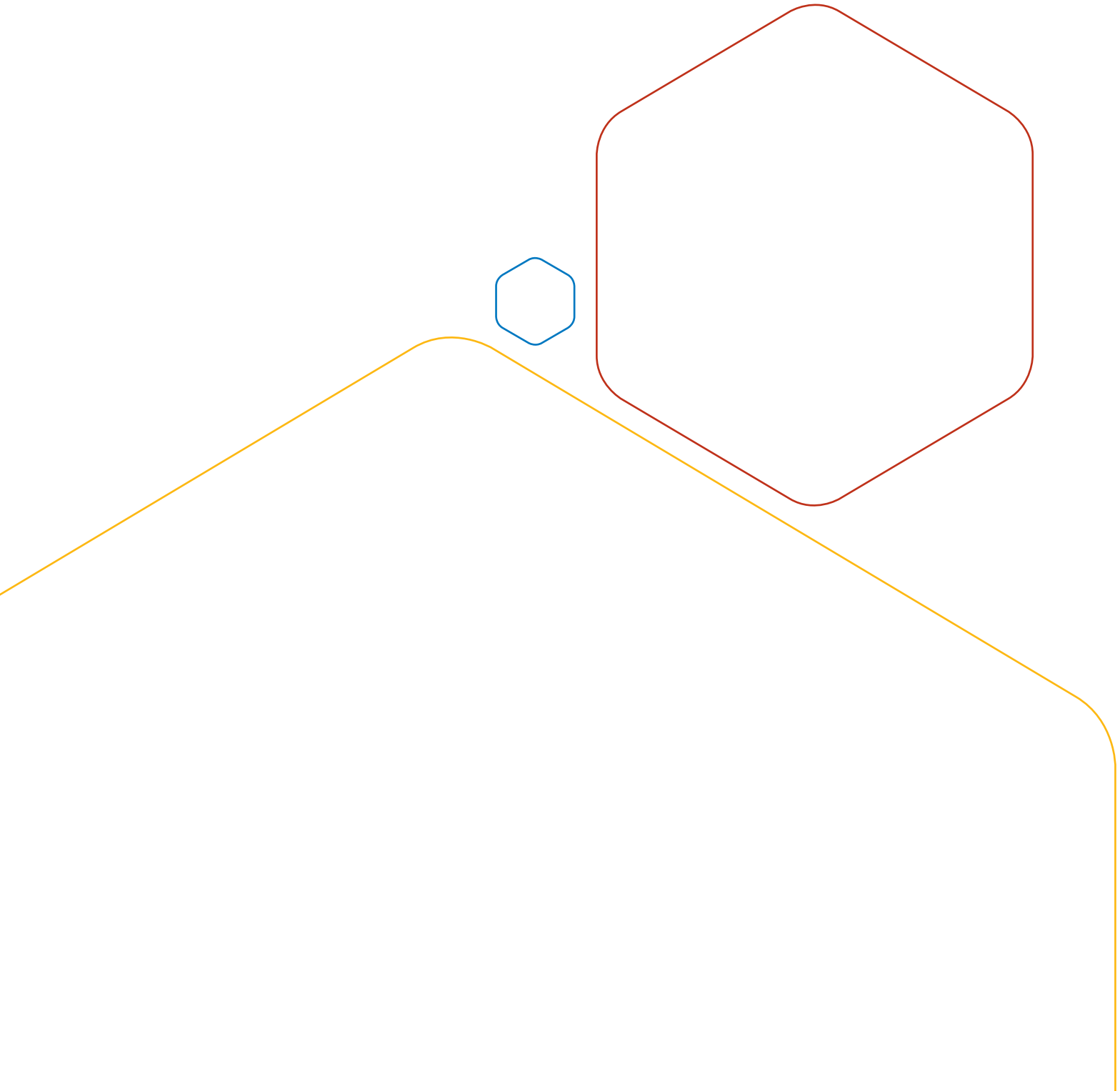
Non-Network Provider
A provider that has not entered into an agreement with BCBSRI or a Blue Cross or Blue Shield plan in another state.

Out-of-pocket Maximum
The total amount of coinsurance that you must pay each calendar year for covered healthcare services provided by network and non-network hospitals, facilities, doctors, and other healthcare providers. The network provider and non-network provider maximum out-of-pocket expenses accumulate separately. Select services do not apply. Please see your subscriber agreement for further details.

Over-the-counter (OTC) Drugs
A drug that you can buy without a prescription. Examples include certain pain relievers, allergy medicines, decongestants, and cough medicines.

Personal Physician
A family practitioner, internist, or pediatrician who provides your routine care and guides you through the healthcare system.

Specialist
A physician who is trained in a specific area of medicine, such as cardiology, dermatology, or oncology.



We're Here to Help You!

If you have questions or need information, we can help. Visit our Web site www.bcbsri.com or call the appropriate phone number below whenever you need assistance.

Individual Sales .....(401) 351-BLUE (2583) or 1-800-505-BLUE

Customer Service: .....(401) 459-5000 or 1-800-639-2227

- **On the Phone:** Monday – Friday, 8:00 a.m. – 8:00 p.m., and Saturday, 8:00 a.m. – 2:00 p.m.
- **In person:** 15 LaSalle Square in Providence RI, Monday – Friday, 8:15 a.m. – 4:30 p.m.
- **After hours:** You can leave a detailed message with our answering service. A customer service representative will contact you the next business day.
- **On the Web:** Use our secure messaging feature on BCBSRI.com to send a message to our Customer Service Department. You'll receive a reply within one business day.
- **TDD (Telecommunications Device for the Deaf):** 1-888-252-5051

Behavioral Healthcare Administrator: .....(401) 277-1344 or 1-800-274-2958

Disease and Case Management .....(401) 459-5573 or 1-888-727-2300, extension 5573

Blue Healthcare Bank.....1-800-663-BLUE or www.bluehealthcarebank.com/members

Wells Fargo Health Benefit Services.....1-866-449-9912 or www.wfhbs.com/bcbsri

Blue Cross Blue Shield of Rhode Island

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www.BCBSRI.com

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