MEMORANDUM OF AGREEMENT BETWEEN THE CITY OF WOONSOCKET, BY AND THROUGH THE WOONSOCKET BUDGET COMMISSION, AND THE ASSOCIATION OF RETIRED WOONSOCKET FIREFIGHTERS ON BEHALF OF ITS RETIREE MEMBERS AND BENEFICIARIES

This Memorandum of Agreement is between and among the City of Woonsocket ("City"), by and through the Woonsocket Budget Commission ("WBC"), on the one hand, and the Association of Retired Woonsocket Firefighters ("Association"), on behalf of its members and beneficiaries ("Retiree Parties"), listed hereto on Attachment 1, on the other. Hereafter the City/WBC and Association shall be referred to collectively as the "Parties." As used at all times in this Memorandum of Agreement:

- "WBC" refers to the Woonsocket Budget Commission, which is established in accordance with R.I. Gen. Laws § 45-9-6, and its agents, employees and representatives, including: (1) its present and former members; (2) the Director of the Rhode Island Department of Revenue; and (3) any and all staff from the Department of Revenue or elsewhere who are employed, retained, or appointed to carry out the responsibilities of the WBC;
- "City" refers to the City of Woonsocket, a municipality of the State of Rhode Island, and its agents, employees, and representatives;
- "City Pension Plan" refers to the locally administered fund that is used to make pension benefit payments, including cost-of-living adjustments, to certain former employees of the City who were members of the City's police and fire departments;
- "Association" refers to the Association of Retired Woonsocket Firefighters, a non-profit corporation representing certain former employees of the Woonsocket Fire Department,

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and their beneficiaries, and its agents, employees, representatives, successors and/or assigns;

- "Pension and Medical Insurance Dispute" refers to the dispute among the WBC and the City, and the Association regarding the lawfulness of the changes implemented by the WBC pursuant to the "Resolution to Reform Pension and Post-Retirement Benefits" adopted by the WBC on March 19, 2013, and any subsequent amendments thereto;
- "Pension Retirees" refers to members of the City Pension Plan, and their beneficiaries, including spouses and surviving spouses, who receive benefits under the City Pension Plan in accordance with the terms set forth in the collective bargaining agreement under which the Pension Retiree retired;
- "Retiree Parties" refers to members of the Association who retired from the City on or before June 30, 2014, and their beneficiaries, including spouses and surviving spouses, covered under and receiving benefits through their participation in the City's pension and/or medical insurance plans; and
- "Medical Insurance" refers to the insurance coverage provided by the City to Retiree Parties for costs incurred by the Retiree Parties in the course of receiving treatment or services for medical reasons, such as preventive care, illness or injury, with the exclusion of treatment or services for dental care, which are typically insured through dental insurance plans.

RECITALS

WHEREAS, in May 2012, the Rhode Island Director of the Department of Revenue appointed a budget commission, at the request of the City Council, in accordance with R.I. Gen. Laws § 45-9-5;

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WHEREAS, as of July 1, 2012, the fund that is used to make pension benefit payments, including cost-of-living adjustments, to certain former employees of the City who had been members of the City's police and fire departments ("City Pension Plan"), was less than sixty percent (60%) funded, and therefore had reached "critical status" under R.I. Gen. Laws § 45-65-4;

WHEREAS, on March 19, 2013, as part of the implementation of a five-year deficit reduction plan, the WBC adopted a Resolution to Reform Pension and Post-Retirement Benefits ("Retiree Reform Resolution"), attached as Exhibit A;

WHEREAS, certain Retiree Parties are members of and receive benefits under the City Pension Plan ("Pension Retirees"), the terms of which are set forth under the collective bargaining agreements that controlled upon the Pension Retirees' respective dates of retirement;

WHEREAS, all Retiree Parties receive medical insurance benefits through the City, the terms of which are set forth in the collective bargaining agreements that controlled upon the Retiree Parties' respective dates of retirement;

WHEREAS, the Retiree Reform Resolution provides for the suspension of the cost-of-living adjustments otherwise applied on behalf of those Pension Retirees entitled to such adjustments under the collective bargaining agreements that controlled upon their respective dates of retirement, and implements changes to the terms and conditions of medical insurance benefits provided to the Retiree Parties;

WHEREAS, the Association and the Retiree Parties could challenge these changes by asserting certain claims and/or invoking certain rights under state and federal law, and by seeking to compel the City to adhere to the terms and conditions set forth in the collective bargaining agreements that controlled upon the Retiree Parties' respective dates of retirement;

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WHEREAS, if the Association or the Retiree Parties were to assert such claims or invoke such rights, the City/WBC would deny the validity or enforceability of such claims or rights, the result of which would be a dispute among the Parties over the lawfulness of the changes implemented under the Retiree Reform Resolution and any subsequent amendments thereto ("Pension and Medical Insurance Dispute"), which dispute would likely lead to costly and time-consuming litigation to the detriment of all Parties;

WHEREAS, the City/WBC and the Association desire to avoid and terminate this Pension and Medical Insurance Dispute, including a potential action that the Association and/or the Retiree Parties might bring to compel the City to adhere to the cost-of-living adjustments to be applied to pension benefit payments paid to the Pension Retirees and to the terms and conditions of the medical insurance benefits to be provided to the Retiree Parties, as set forth in the collective bargaining agreements that controlled upon the Retiree Parties' respective dates of retirement, and to assure one another that no legal action will result relating to the Pension and Medical Insurance Dispute;

WHEREAS, the City/WBC desires that the Association and the Retiree Parties discharge forever, subject to the terms set forth below, all claims, demands, liabilities and causes of action relating to the Pension and Medical Insurance Dispute that the Association and the Retiree Parties may have against the City/WBC, and which have occurred or arisen from the beginning of time through the effective date of this Memorandum of Agreement;

WHEREAS, the Association and its Retiree Parties do not concede that any actions taken by the WBC and/or the City with regard to implementing changes to the Retiree Parties' and Pension Parties' pension and medical benefits were necessary or in accordance with state and/or federal law;

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WHEREAS, the Association and its Retiree Parties desire to settle this matter to avoid costly litigation and mitigate any adverse impact on the City's fisc related thereto;

WHEREAS, the Parties agree that this Memorandum of Agreement is the result of a compromise, reached after good faith negotiations, and that it has been reviewed by counsel of each Party's choice, and that it is not and shall never at any time, for any purpose, be considered an admission of the validity or enforceability of any claims or rights of the Association or the Retiree Parties, or of liability or unlawful conduct by the WBC or the City:

NOW THEREFORE, in consideration of the mutual promises and covenants set forth herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree to be legally bound as follows:

1. Incorporation. The foregoing recitals are a part of this Memorandum of Agreement and hereby incorporated by reference.

2. Cost-of-Living Adjustment. Upon the effective date of this Memorandum of Agreement, the WBC shall adopt a Resolution directing that within one-hundred-and-twenty (120) days of such adoption, the City shall make payment to each eligible Pension Retiree (which does not include surviving spouses or any beneficiaries) in an amount that results from application of a compounded two-percent (2%) cost-of-living adjustment to the pension benefit payment that the Pension Retiree actually received as of July 1, 2014, which adjustment shall be applicable to all pension benefit payments made in fiscal year 2015 (July 1, 2014 – June 30, 2015). Thereafter, the City shall make payment of a compounded two-percent (2%) cost-of-living adjustment to pension benefit payments to the Pension Retirees eligible for such adjustment (which does not include surviving spouses or any beneficiaries) for fiscal year 2017

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(effective July 1, 2016); fiscal year 2019 (effective July 1, 2018); fiscal year 2021 (effective July 1, 2020), fiscal year 2023 (effective July 1, 2022), and then for each fiscal year thereafter. The Resolution shall further provide that:

a. The City shall review experience studies performed by the City's actuary to determine if the mortality table utilized in the valuations is the appropriate mortality table for the police and fire members, and their beneficiaries.

b. When the annual actuarial valuation of the City Pension Plan discloses, based upon prudent assumptions consistent with actuarial standards, which analysis includes the review as provided for in subsection 2(a) above, that the City Pension Plan has achieved a funding level of eighty percent (80%) or greater, and when the City's actuary further determines that granting a three-percent (3%) compounded cost-of-living adjustment for all future years of the City Pension Plan shall not result in the projected funding level falling below eighty percent (80%), then for each fiscal year thereafter, the City shall apply and make payment of a three-percent (3%) compounded cost-of-living adjustment to the Retiree Parties entitled to such cost-of-living adjustment, which does not include surviving spouses or any beneficiaries.

c. When the annual actuarial valuation of the City Pension Plan discloses that the City Pension Plan has achieved a funding level of between seventy-five-percent (75%) and seventy-nine-percent (79%), then the City, by and through the Mayor or his or her designee, shall meet and confer with City Pension Plan members and their representatives, as is feasible, including those who are represented by the Association, to determine if restoring the three-percent

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(3%) compounded cost-of-living adjustment is feasible and fiscally prudent, after taking into account the actuarial cost and impact of such action on all future years of the City Pension Plan.

d. The Association shall receive an Annual Funding Notice, which shall provide information about the status of the City Pension Plan, including funding and investment policies, in the form reflected in Exhibit B, attached hereto.

e. If the City is found by a court of competent jurisdiction to have breached the terms of section (2), by failing to make payment of a two-percent (2%) or three-percent (3%) cost-of-living adjustment under the terms and conditions set forth in that section, then the City shall be responsible to pay reasonable attorneys' fees to the Association, in an amount not exceeding Twenty-Five-Thousand-Dollars-And-No-Cents ($25,000.00), provided that the Association shall make a good faith effort to resolve any claim of breach prior to initiating court action.

3. Lump-Sum Payment. Within thirty (30) days of the effective date of this Memorandum of Agreement, the City shall make a single, one-time lump sum payment to the Association in the amount of Ten-Thousand-Dollars-And-No-Cents ($10,000.00), to be used and apportioned among Association members in whatever manner the Association determines is in the interest of the organization. The Association shall be responsible for making any and all tax payments in accordance with law.

4. Early Retirees: Medical Insurance Plans. Upon the effective date of this Memorandum of Agreement, the WBC shall adopt a Resolution that provides that effective July 1,

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2013, the existing medical insurance coverage provided by the City to all Retiree Parties who have not reached sixty-five (65) years of age (hereafter "Early Retirees/Beneficiaries"), shall be replaced, at the election of the Early Retirees/Beneficiaries, with one of two forms of coverage, i.e.,: (a) 100/80 coinsurance plan with deductible of $500/$1,000 (summary plan description attached as Exhibit C) (hereafter "Option 1"); or (b) 100/80 coinsurance plan with deductible of $2,000/$4,000 (summary plan description attached as Exhibit D) (hereafter "Option 2"). The summaries of benefits and coverage and their terms and conditions, attached hereto as Exhibit C and Exhibit D, are incorporated hereto. The newly elected coverage shall be one individual plan or a family plan provided in accordance with the terms of the applicable eligibility provisions of the collective bargaining agreement under which the Early Retiree retired. The Resolution shall further provide that:

a. Early Retirees/Beneficiaries shall be permitted to change their medical insurance plans between Option 1 and Option 2 during open enrollment periods as established by the third-party administrator, or insurance carrier, as applicable.

b. Early Retirees/Beneficiaries shall not make deductible payments, co-insurance payments or point of delivery payments for covered medical services or prescription drugs (the latter also known as "co-payments" or "co-pays"), in amounts that are in excess of those currently set forth under Option 1 and Option 2.

c. If the City changes to a different third-party administrator, or insurance carrier, as applicable, Early Retirees/Beneficiaries shall be afforded medical

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insurance under plans that provide the same or greater quality of benefits and access to medical providers at a cost that is the same or lower than that afforded under Option 1 and Option 2.

5. Early Retirees: Co-Share Payments. Upon the effective date of this Memorandum of Agreement, the WBC shall adopt a Resolution that provides that from July 1, 2013 through June 30, 2017, as a condition of receiving medical insurance coverage through the City, the Early Retiree/Beneficiary shall make an annual contribution to the cost of medical insurance ("Co-Share Payment"), in the amounts set forth below:

   a. From July 1, 2013 through June 30, 2014, the Early Retiree/Beneficiary who elected coverage under Option 1 shall make a Co-Share Payment in the annual amount equivalent to twenty percent (20%) of the applicable working rate for fiscal year 2014 (individual or family plan), or under Option 2, a Co-Share Payment in the annual amount equivalent to ten percent (10%) of the applicable working rate for fiscal year 2014 (individual or family plan).

   b. From July 1, 2014 through June 30, 2015, the Early Retiree/Beneficiary who elects coverage under Option 1 shall make a Co-Share Payment in the annual amount of $998.95 for an individual plan, or $2,488.30 for a family plan; or under Option 2, a Co-Share Payment in the annual amount of $435.99 for an individual plan, or $1,102.68 for a family plan. Any overpayment under this provision, which was made by an Early Retiree/Beneficiary between July 1, 2014 and the effective date of this Memorandum of Agreement, shall be reimbursed to him/her by way of a credit on the next monthly payment that the Early Retiree/Beneficiary is to make to the City.

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c. From July 1, 2015 through June 30, 2016, the Early Retiree/Beneficiary who elects coverage under Option 1 shall make a Co-Share Payment in the annual amount of $665.96 for an individual plan, or $1,658.87 for a family plan; or under Option 2, a Co-Share Payment in the annual amount of $290.66 for an individual plan, or $735.12 for a family plan.

d. From July 1, 2016 through June 30, 2017, the Early Retiree/Beneficiary who elects coverage under Option 1 shall make a Co-Share Payment in the annual amount of $332.98 for an individual plan, or $829.43 for a family plan, or under Option 2, in the annual amount of $145.33 for an individual plan, or $367.56 for a family plan.

e. Commencing on July 1, 2017, and for all fiscal years thereafter, the Early Retirees/Beneficiaries shall make no Co-Share Payment.

6. Medicare Retirees (Age). Upon the effective date of this Memorandum of Agreement, the WBC shall adopt a Resolution that provides that effective July 1, 2013, the medical insurance coverage provided by the City to Retiree Parties (which beneficiaries are their spouses and surviving spouses only), who are Medicare-eligible because they have reached the age of sixty-five (65) years ("Medicare Retirees-Age") shall be provided through Medicare Parts A and B, with a Medicare Supplement, as described below:

a. For the period from July 1, 2013 through June 30, 2014: (i) the Medicare Retiree-Age shall continue to be responsible for making full payment of the monthly premiums for Medicare Part B and any Part D prescription drug coverage as applicable; and (ii) the City shall pay eighty percent (80%), and

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the Medicare Retiree-Age shall pay twenty percent (20%), of the annual premium cost of either the Medicare Supplement "Plan 65" (summary plan description attached as Exhibit E), or the cost-equivalent plan known as "Blue Chip Plus" (summary plan description attached as Exhibit F), provided that if the Medicare Retiree-Age seeks coverage through an available plan that is more costly than the cost-equivalent plan to Plan 65, such as "Blue Chip Preferred," he or she may purchase that more costly plan by paying to the City the difference between the cost of Plan 65 and that more costly plan.

b. Effective July 1, 2014: (i) the Medicare Retiree-Age shall continue to be responsible for making full payment of the monthly premiums for Medicare Part B and any Part D prescription drug coverage as applicable; and (ii) the City shall pay one-hundred percent (100%) of the annual premium cost of either "Plan 65" (Exhibit E), or the cost-equivalent plan known as "Blue Chip Plus" (Exhibit F), provided that if the Medicare Retiree-Age seeks coverage through an available plan that is more costly than the cost-equivalent plan to Plan 65, such as "Blue Chip Preferred," he or she may purchase that more costly plan by paying to the City the difference between the cost of Plan 65 and that more costly plan. Any overpayment under this provision, which was made by a Medicare Retiree-Age between July 1, 2014 and the effective date of this Memorandum of Agreement, shall be reimbursed to him/her within one-hundred-and-twenty (120) days of the effective date of this Memorandum of Agreement.

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c. The City shall pay on behalf of each Medicare Retiree-Age any penalties imposed by the federal government for late enrollment in Medicare as of April 1, 2013, provided that the Medicare Retiree-Age enrolled in Medicare Part B effective July 1, 2013. Thereafter, the City shall not pay any penalties incurred by a Medicare Retiree-Age for late or untimely enrollment in Medicare; all Retiree Parties shall enroll in Medicare upon achieving eligibility as a condition of receiving the benefits set forth under paragraphs 4 through 6 of this Memorandum of Agreement.

7. Medicare Retirees (SSDI). Upon the effective date of this Memorandum of Agreement, the WBC shall adopt a Resolution that provides that effective July 1, 2013, the medical insurance coverage provided by the City to Retiree Parties (which includes beneficiaries), who are Medicare-eligible because they receive Social Security Disability Insurance ("SSDI") ("Medicare Retirees-SSDI"), shall be provided through Medicare Parts A and B, with a Medicare Supplement, as described below:

   a. The Medicare Retiree-SSDI shall be responsible for making full payment of the monthly premiums for Medicare Part B and any Part D prescription drug coverage as applicable, and the City shall pay one-hundred percent (100%) of the annual premium cost of either "Plan 65" (Exhibit E), or the cost-equivalent plan known as "Blue Chip Plus" (Exhibit F), provided that if the Medicare Retiree-SSDI seeks coverage through an available plan that is more costly than the cost-equivalent plan to Plan 65, such as "Blue Chip Preferred," he or she may purchase that more costly plan by paying to the City the difference between the cost of Plan 65 and that more costly plan.

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b. The City shall pay on behalf of each Medicare Retiree-SSDI any penalties imposed by the federal government for late enrollment in Medicare as of March 31, 2015, provided that the Medicare Retiree-SSDI enrolled in Medicare Part B to become effective July 1, 2015. Thereafter, and subject to the provision set forth above, the City shall not pay any penalties incurred by a Medicare Retiree-SSDI for late or untimely enrollment in Medicare; all Retiree Parties shall enroll in Medicare upon achieving eligibility as a condition of receiving the benefits set forth under paragraphs 4 through 5 and 7 of this Memorandum of Agreement.

8. Surviving Spouses-Line Of Duty. Upon the effective date of this Memorandum of Agreement, the WBC shall adopt a Resolution that provides that Cynthia Guilmette and Annette Laliberte, surviving spouses of firefighters killed in the line of duty within the meaning of Article IV, paragraph 4.1(d) of the collective bargaining agreement between the City and Local 732, International Association of Firefighters, AFL-CIO, shall receive medical insurance coverage through the City as described below:

a. Cynthia Guilmette: Until she reaches Medicare eligibility (based on age or receipt of SSDI), the City shall provide to Ms. Guilmette and her dependents, at Ms. Guilmette's election, individual or family medical insurance coverage under the 100/80 coinsurance plan with deductible of $500/$1,000 (Exhibit C). Effective July 1, 2013, Ms. Guilmette shall not be required to make any Co-Share Payment. Upon reaching eligibility for Medicare, Ms. Guilmette shall enroll in Medicare, Part B, and shall receive medical insurance coverage

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through the City in the same manner as does Annette Laliberte, set forth in subparagraph (b) below.

b. Annette Laliberte: The City shall pay on behalf of Ms. Laliberte one-hundred percent (100%) of the annual premium cost of either "Plan 65" (Exhibit E), or the cost-equivalent plan known as "Blue Chip Plus" (Exhibit F), provided that if Ms. Laliberte seeks coverage through an available plan that is more costly than the cost-equivalent plan to Plan 65, such as "Blue Chip Preferred," she may purchase that more costly plan by paying to the City the difference between the cost of Plan 65 and that more costly plan. In addition, if Ms. Laliberte does not receive prescription drug coverage through a Medicare Advantage plan such as Blue Chip Plus or Blue Chip Preferred, the City shall pay the premium cost of a Group Part D Prescription Drug Plan (summary plan description attached as Exhibit G).

9. Payments by Retiree Parties. Any Retiree Party who, as of the effective date of this Agreement, owes the City monies under paragraphs 5 through 8, after offset for any applicable overpayment made since July 1, 2014, shall make full payment to the City of the amount outstanding by no later than sixty (60) days after the effective date of this Memorandum of Agreement; if he or she fails to make payment by that date, then the City shall terminate his or her medical insurance in accordance with the WBC Resolution Regarding Termination and Reinstatement of Health Insurance for Retirees, adopted on September 23, 2013 ("Resolution for Coverage Termination"), which is incorporated hereto as Exhibit H. Any Retiree Party who, on or after the effective date of this Memorandum of Agreement, is required to make payment to the

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City as described in paragraphs 5 through 8 shall make such payment to the City in monthly installments, submitted in advance, by no later than the seventh (7th) day of each month (the "Due Date"). With the exception of paragraph 1 of the Resolution for Coverage Termination (which is modified by the preceding sentence of this Memorandum of Agreement), all other provisions of the Resolution for Coverage Termination shall control and define the process for termination and reinstatement of coverage for nonpayment and voluntary termination of coverage. After obtaining input from the Retiree Parties, through Association representatives, the City reserves the right to develop and implement a method/process for collecting Co-Share Payments that eases its administrative burden, including but not limited to deduction of the amount due from the pension and cost-of-living adjustment payments, provided that the City affords the Retiree Parties written notice of this method/process at least one month in advance of implementation.

10. Direct Payment. As permitted by Medicare and the City's insurance carrier and/or third-party administrator, the City shall work to implement a process whereby the City shall remit any and all payments made on behalf of Medicare Retirees directly to Medicare and/or the City's insurance carrier and/or third-party administrator.

11. Receivership. In the event that a receiver is appointed under R.I. Gen. Laws § 45-9-7, and the WBC is disbanded, the Rhode Island Department of Revenue shall recommend to the receiver that this Memorandum of Agreement be controlling, as reflected in a letter of commitment by its Director, attached hereto as Exhibit I, and that if the receiver files a petition in the name of the City under Chapter 9, Title 11 of the United States Code, then the Rhode Island Department of Revenue shall recommend to the

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Receiver that the substantive terms of this Memorandum of Agreement be incorporated into the City's so-called "pendency plan" during the pendency of the Chapter 9 bankruptcy case, and/or the City's proposed plan of debt adjustment, to the extent allowed by law.

12. Release. Subject to the exceptions listed below, the Association and the Retiree Parties, each on behalf of its, his, or her heirs, assigns, administrators or executors, hereby release and forever discharge the WBC and the City from any and all manner of actions, causes of action, suits, debts, accounts, contracts, claims, demands, agreements, controversies, judgments, obligations, damages and liabilities of any nature, whether now known, suspected or claimed, which the Association and each Retiree Party ever had, now has, or hereafter may have or claim to have against the WBC or the City ("Claims"), which relate to the Pension and Medical Insurance Dispute, from the beginning of time to the effective date of this Memorandum of Agreement. This Release includes, without limitation, a release of the Association and the Retiree Parties' rights to file suit or otherwise seek restitution for any alleged violation of local, state or federal law, regulation, or ordinance relating to the Pension and Medical Insurance Dispute, and specifically to any Claim based upon a lack of authority, breach of contract, or alleged violation of the Contract Clause under the United States or Rhode Island Constitutions. The Association and Retiree Parties intend this release to be all-encompassing and to act as a full and total release of any and all Claims each may have against the WBC or the City relating to the Pension and Medical Insurance Dispute, even if not listed specifically herein. Notwithstanding anything set forth herein to the contrary, in the event that this Memorandum of

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Agreement is rejected in a Chapter 9 case filed by a receiver for the City appointed by the State of Rhode Island's Director of the Department of Revenue under R.I. Gen. Laws Chapter 45-9: (i) this entire Memorandum of Agreement shall be deemed rejected, including, without limitation, this release; and (ii) pursuant to the terms of Bankruptcy Code Section 365, the claim of the Association and the Retiree Parties on account of said rejection will be as of the petition date of the Chapter 9 case. In the event that the WBC or the City breaches the terms of this Memorandum of Agreement, and a receiver has not sought to reject this Memorandum of Agreement in a Chapter 9 case, the release of Claims and promises not to file any action contained herein shall be void as of the date of the breach and the Association and the Retiree Parties shall have all of their rights preserved with respect to claims arising after the date of breach; provided however, said Association and Retiree Parties shall not have the right to make claims or file any actions seeking damages related to the period prior to the date of said breach.

13. Agreement Not to File Any Action. Provided that this Memorandum of Agreement remains in full force and effect, the Association and the Retiree Parties acknowledge and agree not to commence or prosecute, or assist in the commencement or prosecution of, or in any way to cause, permit, or advise to be commenced or prosecuted against the WBC or the City in any action or proceeding, any demands, causes of action, obligations, damages, or liabilities related to the Pension and Medical Insurance Dispute.

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14. Severability. If any portion of this Memorandum of Agreement is held to be invalid or unenforceable, all remaining provisions shall otherwise remain in full force and effect and be construed as if the invalid portion(s) had not been included.

15. Assignment. If and when the WBC disbands, this Memorandum of Agreement shall remain in full force and effect between the City and the Association and Retiree Parties, and shall be binding upon those Parties, and the Parties' respective successors and assigns.

16. Entire Agreement. This Memorandum of Agreement is intended by all Parties as a final expression of their agreement and as a complete and exclusive statement of the terms thereof. This Memorandum of Agreement shall supersede all prior understandings, oral and written, heretofore had between the Parties in connection with this matter. Any amendments to this Memorandum of Agreement shall be by mutual written agreement.

17. Governing Laws. This Memorandum of Agreement shall in all respects be interpreted, enforced, and governed and construed by and under the laws of the State of Rhode Island.

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18. Effective Date. The Memorandum of Agreement shall become effective upon signature of all Parties listed below.

The City of Woonsocket,
By: The Honorable Lisa Baldelli-Hunt, Mayor

Lisa Baldelli-Hunt Date: 12.18.14

The Woonsocket Budget Commission
By: Dina Dutremble, Chair

Dina Dutremble Date: 12/23/14

The Association of Retired Woonsocket Firefighters
On behalf of the Association and the Retiree Parties
Listed in Attachment 1
By: Rene R. Menard, President

R R Menard Date: 12-18-14

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As amended by Exhibit J
dated 12/23/2014
RRM dated 10/23/14
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EXHIBIT

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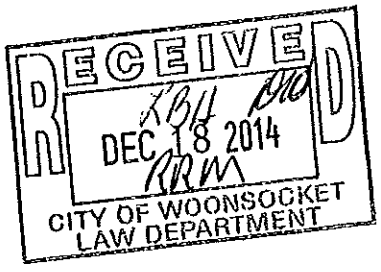

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City of Woonsocket
Rhode Island

MARCH 13 A.D. 2013

Resolution

RESOLUTION TO REFORM PENSION AND POST-RETIREMENT BENEFITS

WHEREAS, The City of Woonsocket ("City") is confronting a fiscal crisis so severe that it poses an imminent danger to the safety of the citizens of the City; and

WHEREAS, Over the past ten years, the City has attempted to resolve the chronic nature of this fiscal crisis by taking such measures as: (1) borrowing over $100 million through issuance of pension obligation and deficit reduction bonds, (2) cutting personnel costs; (3) deferring capital expenditures; (4) closing public schools; and (4) obtaining concessions from employees; and

WHEREAS, Despite these and other efforts, the fiscal situation confronting the City has remained so dire that the state Director of Revenue appointed a fiscal overseer, and then a budget commission, in accordance with R.I. Gen. Laws §§ 45-9-3 & 5, for the purpose of presenting a balanced budget and achieving fiscal stability in the City; and

WHEREAS, Shortly after its appointment in May 2012, the budget commission was compelled to take immediate and short-term emergency measures to ensure that the City was able to pay its delinquent bills to vendors; and

WHEREAS, The budget commission thereafter reviewed the City's finances to develop a five-year plan ("Baseline"); and

WHEREAS, This Baseline, which projects City budgets from fiscal year 2013 through fiscal year 2017, shows that if nothing changes, the City will be confronting a cumulative deficit of $105.5 million by the end of fiscal year 2017, which amount includes monies for the payment of present and future post-employment benefits other than pensions; and

WHEREAS, Based on the actuarial valuation report for the plan year beginning on July 1, 2012, the City fire and police pension plans had an unfunded accrued liability of $42.6 million, and therefore only fifty-seven (57%) of the amount needed to pay out projected benefits; and

WHEREAS, If nothing changes, the pension plans will have insufficient funds to make any benefit payments to retirees within approximately eight years; and

WHEREAS, This underfunding of the City's pension plans places them in "critical status" under R.I. Gen. Laws § 45-65-4, and requires that, under R.I. Gen. Laws § 45-65-6(2), the City submit a reasonable alternative funding improvement plan to the state study commission established under R.I. Gen. Laws § 45-65-8; and

WHEREAS, Based on actuarial valuations of the post-retirement medical insurance plans for the City employees and retirees (including retirees from the Woonsocket Education Department), as of July 1, 2011, the plans had an unfunded accrued liability of $200.7 million, and an annual required contribution of $20 million; and

WHEREAS, The City cannot make the $20 million annual required contribution as set forth in these actuarial valuations without incurring the debt projected by the Baseline, which debt would render the City inoperable, and require appointment of a receiver under R.I. Gen. Laws § 45-9-7; and

WHEREAS, The budget commission has proposed a five-year deficit reduction plan ("5-Year Plan"), that takes into account and ensures payment of both pension and other post-employment benefits to retirees; and

WHEREAS, This 5-Year Plan, if implemented, will (1) enable the City to achieve a positive operating balance by the end of fiscal year 2014, and a positive fund balance (including the accounting for other

SECTION 5. Absent agreement to the contrary between the Budget Commission and retiree representatives, all health insurance benefits currently provided to retirees of the City (including but not limited to those formerly employed by the Woonsocket Education Department), and their beneficiaries, who are not yet eligible or who are ineligible for Medicare benefits shall change, effective July 1, 2013, to a standard health plan ("Uniform Health Plan") for all City employees and retirees and their beneficiaries, other than those eligible for Medicare, and the City shall cover eighty percent (80%) of the cost, and the retiree, twenty (20%) of the cost of such Uniform Health Plan, *provided that* those retirees who are ineligible for Medicare must provide proof of ineligibility through a written letter of denial from the federal government by no later than March 28, 2013.

SECTION 6. This Resolution shall take effect immediately upon its passage by the City Council.

John F. Ward

John F. Ward, City Council President
Per Request of Administration

IN CITY COUNCIL March 18, 2013 – Read by title, amended and passed as amended.

SECTION 3. As a condition of receiving or continuing to receive health care benefits, all individuals who have retired or retire from City, and their beneficiaries, who become eligible for Medicare in the future (collectively "Future Medicare-Eligible Retirees and Beneficiaries), shall enroll in Medicare on the date upon which they become eligible. Irrespective of whether Future Medicare-Eligible Retirees and Beneficiaries enroll in Medicare, all health benefits provided to Future Medicare-Eligible Retirees and Beneficiaries shall end on the ~~June 30th date that concludes the fiscal year during which they have attained eligibility~~ last day of the month during which each Future Medicare-Eligible Retirees and Beneficiary first becomes eligible to receive Medicare coverage, except that those who retired and are eligible to receive benefits under a pre-existing collective bargaining agreement that provides Medicare Supplement Insurance shall be provided such coverage; and

Amended and passed by the Woonsocket Budget Commission – March 19, 2013

Amendments:

The third "Whereas" paragraph is amended as follows:

Despite these and other efforts, the fiscal situation confronting the City has remained so dire that the state Director of Revenue appointed ~~a fiscal overseer, and then~~ a budget commission, at the request of the City Council, in accordance with R.I. Gen. Laws §§45-9-~~3 &~~ 5, for the purpose of presenting a balanced budget and achieving fiscal stability in the City; and

The eleventh "Whereas" paragraph is amended as follows:

The City cannot make the $20 million annual required contribution as set forth in these actuarial valuations without incurring the ~~debt~~ deficit projected by the Baseline, which ~~debt~~ deficit would render the City inoperable, and would likely require appointment of a receiver under R.I. Gen. Laws §45-9-7; and

William Sequino

William Sequino, Jr., Chairman
Woonsocket Budget Commission

12/23/14

EXHIBIT
B

12/23/14

ANNUAL FUNDING NOTICE
For
[*insert name of pension plan*]

Introduction

This notice includes important information about the funding status of your pension plan ("the Plan"), as well as other information such as participant information and funding and investment policies. All locally-administered pension plans must provide this notice every year regardless of their funded status. This notice is provided for informational purposes and you are not required to respond in any way. As a plan member, you are responsible for providing the plan sponsor with your current address and contact information at all times. This notice is for the plan year beginning [*insert beginning date*] and ending [*insert ending date*] ("Plan Year").

How Well Funded Is Your Plan

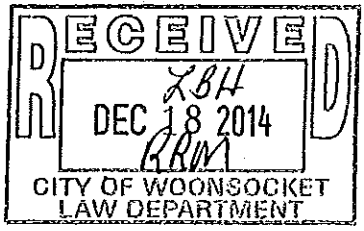
[Under Rhode Island law], the plan must report how well it is funded by using a measure called the "funded ratio." This percentage is obtained by dividing the Plan's Assets by Plan Liabilities on the Valuation Date for the plan year. In general, the higher the percentage, the better funded the plan. Your Plan's funded ratio percentage for the Plan Year and each of the two preceding plan years is shown in the chart below, along with a statement of the value of the Plan's assets and liabilities for the same period. In addition, the required funding payment and the planned contribution for the plan year, as well as the required funded payment and actual payments for the two preceding plan years are shown, along with the funded percentage for each year.

Summary of Key Valuation, Funding and Investment Data

		[Insert plan year- most recent]	[Insert plan year - preceding	[Insert plan year - 2 years preceding]
1	Valuation date	[xx/xx/xx]	[xx/xx/xx]	[xx/xx/xx]
2	Plan assets	[amount]	[amount]	[amount]
3	Plan liabilities	[amount]	[amount]	[amount]
4	Funded ratio	[=line2/line3]	[=line2/line3]	[=line2/line3]
5	Actuarially determined contribution	[amount]	[amount]	[amount]
6a.	Funding from general fund	[amount]	[amount]	[amount]
6b.	Funding from non-general fund	[amount]	[amount]	[amount]
6	Total funding	[amount]	[amount]	[amount]
7	Planned/actual payment	[amount]	[amount]	[amount]
8	Percentage contributed	[line7/line 5]	[line7/line 5]	[line7/line 5]
9	Money weighted rate of return	[percentage]	[percentage]	[percentage]

Summary of Key Values

12/23/14



Plan Assets and Plan Liabilities, Contributions and Rate of Return

Total Plan Assets is the value of the Plan's assets on the Valuation Date (see line 2 in the chart above). Plan Liabilities shown in line 3 of the chart above is the amount the Plan needs on the Valuation Date to pay for promised benefits under the plan. The actual contribution and money weighted return on investments in accordance with GASB 67 are also shown.

Participant Information

The total number of participants in the Plan as of the Plan's valuation date was [*insert number*]. Of this number, [*insert number*] were active participants, [*insert number*] were retired or separated from service and receiving benefits, and [*insert number*] were retired or separated from service and entitled to future benefits.

Funding & Investment Policies

Every pension plan must have a procedure for establishing a funding policy to carry out plan objectives. A funding policy relates to the level of assets needed to pay for promised benefits. The funding policy of the Plan is [*insert a summary statement of the Plan's funding policy*].

Once money is contributed to the Plan, the money is invested by plan officials, called fiduciaries, who make specific investments in accordance with the Plan's investment policy. Generally speaking, an investment policy is a written statement that provides the fiduciaries who are responsible for plan investments with guidelines or general instructions concerning investment management decisions. The investment policy of the Plan is [*insert a summary statement of the Plan's investment policy*].

Under the Plan's investment policy, the Plan's assets were allocated among the following categories of investments, as of the end of the Plan Year. These allocations are percentages of total assets:

Asset Allocation	Percentage
1. Cash (interest bearing and non-interest bearing)	_____
2. U. S. Government securities	_____
3. Specify	_____
4. Specify	_____

For information about the plan's investment in any of the investments described in the chart above, contact: [*insert the name, telephone number, email address or mailing address of the designated municipal representative*].

Events Having a Material Effect on Assets or Liabilities

[State law] requires the plan administrator to provide in this notice a written explanation of events, taking effect in the current or future plan years, which are expected to have a material effect on plan liabilities or assets. Material effect events are occurrences that tend to have a significant impact on a plan's funding condition. For example, changes made to the actuarial assumptions should be included as well as events expected to increase or decrease total plan assets or plan liabilities by five percent or more. For the plan year beginning on [*insert the first day of the current plan year (i.e., the year after the notice year)*] and ending on [*insert the last day of the current plan year*], the following events are expected to have such an effect: [*insert explanation of any plan amendment, scheduled benefit increase or reduction, or other*

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known event taking effect in the current plan year and having a material effect on plan liabilities or assets for the year, as well as a projection to the end of the current plan year of the effect of the amendment, scheduled increase or reduction, or event on plan liabilities].

Right to Request a Copy of the Annual Report

A plan sponsor is required to file valuation and experience reports for the plan. Copies of the reports are available from the Department of Revenue, Division of Municipal Finance (DMF), One Capitol Hill, Providence, RI 02903, or by visiting the DMF website at www.municipalfinance.ri.gov. For 2012 and subsequent plan years, you may obtain an electronic copy of the plan's valuation report by going to this website or you may obtain a copy by making a written request to the plan administrator. [*If the Plan's annual report is available on an Intranet website maintained by the plan sponsor (or plan administrator on behalf of the plan sponsor), modify the preceding sentence to include a statement that the annual report also may be obtained through that website and include the website address.*] Individual information, such as the amount of your accrued benefit under the plan, is not contained in the annual report. If you are seeking information regarding your benefits under the plan, contact the plan administrator identified below under "Where to Get More Information." Also, audited financial statements contain plan information in the footnotes and can be viewed on the DMF website link shown above.

Actuarial Information on File with the Division of Municipal Finance

Pursuant to R.I. General Laws §45-65-6 a plan sponsor must provide actuarial information about the plan under certain circumstances, such as when the funded percentage of the plan falls below 60 percent. The sponsor of the Plan, [*enter name of plan sponsor*], is subject to this requirement to provide plan actuarial information. The DMF uses this information for oversight and monitoring purposes.

Where to Get More Information

For more information about this notice, you may contact [*enter name of plan administrator*], at [*enter phone number and address and insert email address if appropriate*]. For more information about the DMF, go to DMF's website, www.municipalfinance.ri.gov. Note that audited financial statements will also provide additional information. Audited financial statements can be accessed on DMF's website.

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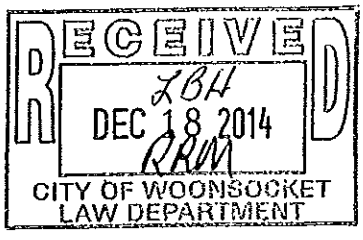

EXHIBIT

C

12/23/14

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

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

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

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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For In Network providers **$500** for an individual plan / **$1000** for a family plan. For Out-of-Network providers **$1000** for an individual plan / **$2000** for a family plan. Doesn't apply to preventive services, services with a fixed dollar copay, prescription drugs and diagnostic testing.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For In Network providers **$1500** for an individual plan / **$3000** for a family plan. For Out-of-Network providers **$3000** for an individual plan / **$6000** for a family plan.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

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

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

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

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	20% coinsurance after deductible	none
	Specialist visit	$30 copay per visit	20% coinsurance after deductible	none
	Other practitioner office visit	$30 copay per visit	20% coinsurance after deductible	Chiropractic Services are limited to 12 visits per year
	Preventive care/screening/immunization	No Charge	20% coinsurance after deductible	For additional details, please see your plan documents or visit www.BCBSRI.com/providers/policies
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance after deductible	Preauthorization is recommended for certain services
	Imaging (CT/PET scans, MRIs)	No Charge after deductible	20% coinsurance after deductible	Preauthorization is recommended

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Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.BCBSRI.com.	Tier 1 generally low cost generic drugs	$10 copay per prescription (retail) $25 copay per prescription (mail-order)	Not covered	No Charge for certain preventive drugs
	Tier 2 generally high cost generic and preferred brand name drugs	$20 copay per prescription (retail) $50 copay per prescription (mail-order)	Not covered	Preauthorization is required for certain drugs
	Tier 3 non- preferred brand name drugs	$30 copay per prescription (retail) $75 copay per prescription (mail-order)	Not covered	Preauthorization is required for certain drugs
	Tier 4 specialty prescription drugs	$50 copay per prescription (specialty pharmacy only)	50% coinsurance	Preauthorization is required for certain drugs; Infertility drugs: 20% coinsurance
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible	20% coinsurance after deductible	Preauthorization is recommended
	Physician/surgeon fees	No Charge after deductible	20% coinsurance after deductible	——————none——————
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay per visit	Copay waived if admitted
	Emergency medical transportation	$50 copay per trip	$50 copay per trip	——————none——————
	Urgent care	$30 copay per urgent care center visit	$30 copay per urgent care center visit	Applies to the visit only. If additional services are provided additional out of pockets costs would apply based on services received.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	20% coinsurance after deductible	45 day limit per inpatient rehabilitation facility; Preauthorization is recommended

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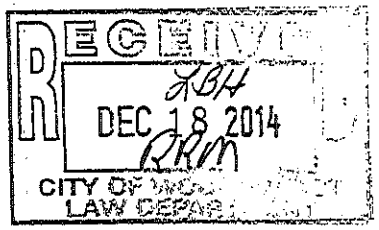
Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
	Physician/surgeon fee	No Charge after deductible	20% coinsurance after deductible	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay/office visit No Charge after deductible for outpatient services	20% coinsurance after deductible/office visit 20% coinsurance after deductible for outpatient services	Preauthorization is recommended for certain services
	Mental/Behavioral health inpatient services	No Charge after deductible	20% coinsurance after deductible	Preauthorization is recommended
	Substance use disorder outpatient services	$30 copay/office visit No Charge after deductible for outpatient services	20% coinsurance after deductible/office visit 20% coinsurance after deductible for outpatient services	Preauthorization is recommended for certain services
	Substance use disorder inpatient services	No Charge after deductible	20% coinsurance after deductible	Preauthorization is recommended
If you are pregnant	Prenatal and postnatal care	No Charge after deductible	20% coinsurance after deductible	——————none——————
	Delivery and all inpatient services	No Charge after deductible	20% coinsurance after deductible	Preauthorization is recommended



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

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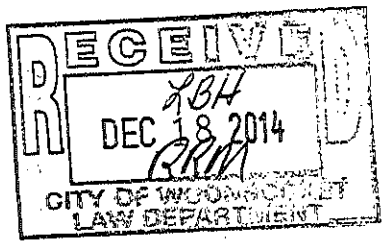
Excluded Services & Other Covered Services:

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

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



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Your Rights to Continue Coverage:

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

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

Your Grievance and Appeals Rights:

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

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

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

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

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,970
- **Patient pays** $570

Sample care costs:

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

Patient pays:

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

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

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

Sample care costs:

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

Patient pays:

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

These examples are based on coverage for an individual plan.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

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

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

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

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

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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For In Network providers **$500** for an individual plan / **$1000** for a family plan. For Out-of-Network providers **$1000** for an individual plan / **$2000** for a family plan. Doesn't apply to preventive services, services with a fixed dollar copay, prescription drugs and diagnostic testing.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For In Network providers **$1500** for an individual plan / **$3000** for a family plan. For Out-of-Network providers **$3000** for an individual plan / **$6000** for a family plan.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

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

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

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

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

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	20% coinsurance after deductible	——————none——————
	Specialist visit	$30 copay per visit	20% coinsurance after deductible	——————none——————
	Other practitioner office visit	$30 copay per visit	20% coinsurance after deductible	Chiropractic Services are limited to 12 visits per year
	Preventive care/screening/immunization	No Charge	20% coinsurance after deductible	For additional details, please see your plan documents or visit www.BCBSRI.com/providers/policies
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance after deductible	Preauthorization is recommended for certain services
	Imaging (CT/PET scans, MRIs)	No Charge after deductible	20% coinsurance after deductible	Preauthorization is recommended

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Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.BCBSRI.com.	Tier 1 generally low cost generic drugs	$10 copay per prescription (retail) $25 copay per prescription (mail-order)	Not covered	No Charge for certain preventive drugs
	Tier 2 generally high cost generic and preferred brand name drugs	$20 copay per prescription (retail) $50 copay per prescription (mail-order)	Not covered	Preauthorization is required for certain drugs
	Tier 3 non- preferred brand name drugs	$30 copay per prescription (retail) $75 copay per prescription (mail-order)	Not covered	Preauthorization is required for certain drugs
	Tier 4 specialty prescription drugs	$50 copay per prescription (specialty pharmacy only)	50% coinsurance	Preauthorization is required for certain drugs; Infertility drugs: 20% coinsurance
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible	20% coinsurance after deductible	Preauthorization is recommended
	Physician/surgeon fees	No Charge after deductible	20% coinsurance after deductible	——————none——————
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay per visit	Copay waived if admitted
	Emergency medical transportation	$50 copay per trip	$50 copay per trip	——————none——————
	Urgent care	$30 copay per urgent care center visit	$30 copay per urgent care center visit	Applies to the visit only. If additional services are provided additional out of pockets costs would apply based on services received.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	20% coinsurance after deductible	45 day limit at an inpatient rehabilitation facility. Preauthorization is recommended

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
	Physician/surgeon fee	No Charge after deductible	20% coinsurance after deductible	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay/office visit No Charge after deductible for outpatient services	20% coinsurance after deductible/office visit 20% coinsurance after deductible for outpatient services	Preauthorization is recommended for certain services
	Mental/Behavioral health inpatient services	No Charge after deductible	20% coinsurance after deductible	Preauthorization is recommended
	Substance use disorder outpatient services	$30 copay/office visit No Charge after deductible for outpatient services	20% coinsurance after deductible/office visit 20% coinsurance after deductible for outpatient services	Preauthorization is recommended for certain services
	Substance use disorder inpatient services	No Charge after deductible	20% coinsurance after deductible	Preauthorization is recommended
If you are pregnant	Prenatal and postnatal care	No Charge after deductible	20% coinsurance after deductible	——————none——————
	Delivery and all inpatient services	No Charge after deductible	20% coinsurance after deductible	Preauthorization is recommended

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

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up, child
- Glasses, child
- Long-term care
- Routine foot care unless to treat a systemic condition
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Most coverage provided outside the United States. Contact Customer Service for more information.
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage:

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

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

Your Grievance and Appeals Rights:

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

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

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

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

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About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,970
- **Patient pays** $570

Sample care costs:

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

Patient pays:

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

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

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

Sample care costs:

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

Patient pays:

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

These examples are based on coverage for an individual plan.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

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

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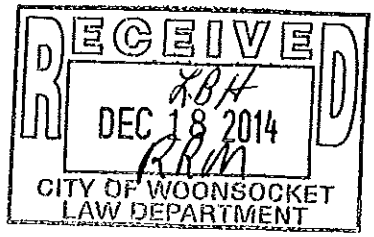

Blue Cross Blue Shield of Rhode Island **HealthMate Coast-to-Coast**

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

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

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

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

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

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

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

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

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

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

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

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

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up, child
- Glasses, child
- Long-term care
- Routine foot care unless to treat a systemic condition
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Most coverage provided outside the United States. Contact Customer Service for more information.
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage:

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

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

Your Grievance and Appeals Rights:

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

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

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

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

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About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

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

Sample care costs:

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

Patient pays:

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

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

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

Sample care costs:

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

Patient pays:

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

These examples are based on coverage for an individual plan.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up, child
- Glasses, child
- Long-term care
- Routine foot care unless to treat a systemic condition
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Most coverage provided outside the United States. Contact Customer Service for more information.
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage:

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

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

Your Grievance and Appeals Rights:

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

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Routine obstetric care	$2,100
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Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

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Limits or exclusions	$30
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(routine maintenance of a well-controlled condition)

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Sample care costs:

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Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

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Copays	$400
Coinsurance	$0
Limits or exclusions	$40
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These examples are based on coverage for an individual plan.

Questions and answers about the Coverage Examples:

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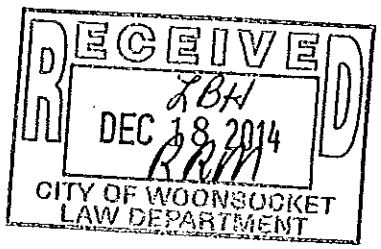
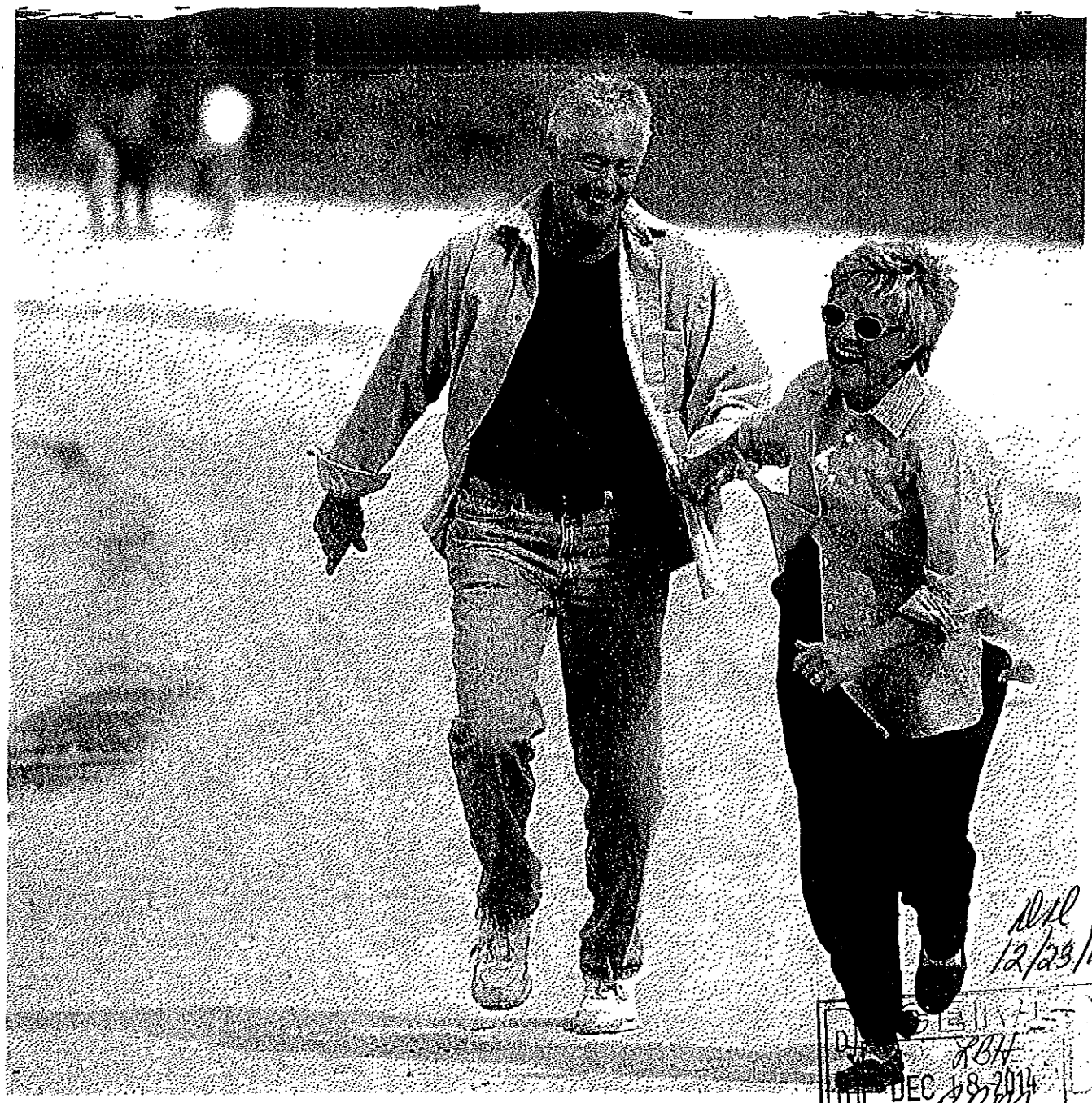


2014 Group Plan 65
Plan Highlights Without the Skilled Nursing Benefit

Blue Cross Blue Shield of Rhode Island



Plan 65®

Medicare Supplement

Group Plan 65 is a Medicare supplement plan, also known as "Medigap," that picks up where Medicare leaves off, making it easier for you to budget for your healthcare expenses. Group Plan 65 provides flexibility, options, and added discounts—all from a trusted, local company.

You're free to seek care from the Original Medicare-participating providers of your choice, anywhere in the country. Plan 65 pays for Original Medicare's cost-sharing, such as deductibles and coinsurance. If Original Medicare does not cover a service, your supplemental plan will also not cover that service, unless otherwise noted.

Plan Benefit	With Original Medicare you pay	With Medicare and Group Plan 65 you pay
Doctor Visits	20% of Medicare-approved amounts after Part B deductible $0 for "Welcome to Medicare" and yearly wellness visits	$0
Inpatient Hospital Care* (Includes substance abuse, mental health, rehabilitation, and inpatient surgery facility services)		
• First 60 days	An initial deductible of $1,216**	$0
• Days 61 – 90	$304 each day**	$0
• 60 lifetime reserve days	$608 each lifetime reserve day**	$0
• Additional lifetime maximum benefit – 365 days	All costs	$0
Skilled Nursing Facility Care* (In a Medicare-certified skilled nursing facility)		
• First 20 days	$0	$0
• Days 21 – 100	$152 each day**	$152 each day**
• 101 days and after	All costs	All costs
Outpatient Surgery Services	20% of Medicare-approved amounts after Part B deductible	$0
Emergency Room Care (You may go to an emergency room if you believe your health is in serious danger.)	20% of Medicare-approved amounts after Part B deductible	$0
Urgently Needed Care (This is not emergency care—your health is not in serious danger.)	20% of Medicare-approved amounts after Part B deductible	$0
Ambulance Services	20% of Medicare-approved amounts after Part B deductible	$0
Diagnostic Tests, X-rays, and Lab Services	20% of Medicare-approved amounts after Part B deductible for diagnostic tests and X-rays $0 for Medicare-covered lab services	$0
Durable Medical Equipment	20% of Medicare-approved amounts after Part B deductible	$0
Prosthetic Devices	20% of Medicare-approved amounts after Part B deductible	$0

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Plan Benefit	With Original Medicare you pay	With Medicare and Group Plan 65 you pay
Home Healthcare	$0 for Medicare-covered home health visits	$0
Foreign Travel Care	All costs	20% after $250 annual deductible for emergency healthcare during the first 60 days of each trip. There is a $50,000 lifetime maximum.
Non-routine Hearing Services	20% of Medicare-approved amounts after Part B deductible for diagnostic hearing exams	$0
Non-routine Vision Care	20% of Medicare-approved amounts after Part B deductible for diagnosis and treatment of diseases and conditions of the eye	$0
Non-routine Podiatry Services	20% of Medicare-approved amounts after Part B deductible	$0
Chiropractic Services (limited)	20% of Medicare-approved amounts after Part B deductible	$0
Immunizations (Flu shots, pneumonia vaccine, and for people with Medicare who are at high risk: hepatitis B vaccine)	$0	$0
Bone Mass Measurement (For people with Medicare who are at risk)	$0	$0
Colorectal Screening Exams	$0 May be charged 20% of the Medicare-approved amount for doctor's visit	$0
Diabetes Screening (For people with Medicare who are at risk)	$0	$0
Annual Mammography Screening (For women with Medicare)	$0	$0
Pap Tests and Pelvic Exams (For women with Medicare)	$0	$0
Prostate Cancer Screening Exams (For men with Medicare)	20% of Medicare-approved amount for digital rectal exam after the Part B deductible. In a hospital outpatient setting, you pay a copayment. $0 for the Prostate Specific Antigen (PSA) Test	$0

2014 Part A Deductible = $1,216 per benefit period**
2014 Part B Deductible = $147 per calendar year**

All services should be received from an Original Medicare-participating provider, except in emergencies. To be eligible for Group Plan 65, you must be enrolled in both Part A and Part B of the Original Medicare Program.

*A benefit period begins on the first day you receive services as an inpatient in a hospital, and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 consecutive days.

**These coinsurances and deductibles are current for 2014 and are subject to change on an annual basis.

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Questions?

To enroll or learn more about our Group Plan 65 Medicare Supplement plan without the skilled nursing benefit, call today at 1-800-505-BLUE (2583). TTY/TDD users can call 711.

If you are already a member of Group Plan 65 and have questions about your plan, please call Customer Service at 1-800-639-2227. TTY/TDD users can call 711. Customer Service hours are Monday through Friday, 8:00 a.m. to 8:00 p.m.

Blue Cross Blue Shield of Rhode Island

www.bcbsri.com

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The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan. Limitations, copayments, and restrictions may apply. [Benefits, formulary, pharmacy network, premium and/or co-payments/ co-insurance] may change on January 1 of each year. Blue Cross & Blue Shield of Rhode Island is an HMO plan with a Medicare contract. Enrollment in Blue Cross & Blue Shield of Rhode Island depends on contract renewal. An independent licensee of the Blue Cross and Blue Shield Association.

Blue Cross Blue Shield of Rhode Island

www.bcbsri.com

500 Exchange Street Providence, RI 02903-2699

Blue Cross Blue Shield of Rhode Island

2014 Retiree BlueCHiP for Medicare Group Plus (HMO) Plan Highlights

Casey Farm, Saunderstown, RI

Here's an overview of premiums, copayments, and coinsurance costs for your plan option.

Questions?

To enroll or to learn more about how BlueCHiP for Medicare Group plans can help meet your healthcare needs, please call today: **1-800-505-2583. TTY/TDD: 711.** Our hours are: **October 1, 2013 - February 14, 2014:** Seven days a week, 8:00 a.m. to 8:00 p.m.; **February 15, 2014 - September 30, 2014:** Monday - Friday, 8:00 a.m. to 8:00 p.m.

Plan Features	BlueChip for Medicare Group Plus (HMO)
Monthly Premium[1]	$153
Out-of-pocket Maximum[2]	$3,000
Copayments	
PCP office visits	$10
Specialist office visits	$30
Hospitalization	
Inpatient	$250 per admission per benefit period
Outpatient	20% coinsurance
Skilled nursing facility	Days 1-29: $0/day Days 30-100: $50/day
Diagnostic tests, X-rays, and lab services[3]	$0 for X-ray and lab services; $50/day for MRI/CT scan
DME/Home healthcare	$0
Emergency room	$65/visit
Ambulance	$50/day
Out-of-network Costs for Point-of-Service (POS) Option	N/A
Prescription Drugs[4]	You pay the following amounts until total yearly drug costs reach $2,850
Tier 1 (generic)	$8
Tier 2 (preferred brand)	$24
Tier 3 (non-preferred brand)	$52
Tier 4 (specialty tier)	25%
Catastrophic Coverage	After total out-of-pocket costs reach $4,550 you pay the greater of $2.55, $6.35, or 5% coinsurance.
Additional Benefits	
Living Fit	$5/month
Vision hardware	$70/year
Hearing aids	N/A

You are covered for the following dental benefits. You must receive these services from one of our participating dentists. To get the most up-to-date information about participating providers, please visit BCBSRI.com.

Plan Features	Dental Benefits
Preventive Services	
Annual Exam	You pay nothing.
Cleanings	You pay nothing. One cleaning per calendar year
X-rays	
Bitewing X-rays	You pay nothing. One set per calendar year
Full mouth set (one set every five years)	N/A
Individual X-rays	N/A
Comprehensive Services	
Includes fillings; simple extractions; minor treatment to relieve acute pain; oral surgery; root canal therapy; biopsies; and denture repairs	N/A
Annual Benefit Maximum	N/A

[1] Must have Medicare Part A and Medicare Part B to enroll. You must continue to pay your monthly Medicare Part B premiums.

[2] The out-of-pocket maximum includes only Medicare-covered services. This is the most you would pay for these services during a calendar year. You must receive all routine care from plan providers.

[3] Review may include but is not limited to preauthorization and/or continued treatment by the Plan and/or Plan designee.

[4] After your total yearly drug costs reach $2,850, you pay 47.5% of the cost (plus the dispensing fee) on brand-name drugs and pay only 72% of the cost of generic drugs until your yearly out-of-pocket drug costs reach $4,550, unless you are getting Extra Help.

The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan. Limitations, copayments, and restrictions may apply. [Benefits, formulary, pharmacy network, premium and/or co-payments/ co-insurance] may change on January 1 of each year. Blue Cross & Blue Shield of Rhode Island is an HMO plan with a Medicare contract. Enrollment in Blue Cross & Blue Shield of Rhode Island depends on contract renewal. An independent licensee of the Blue Cross and Blue Shield Association.

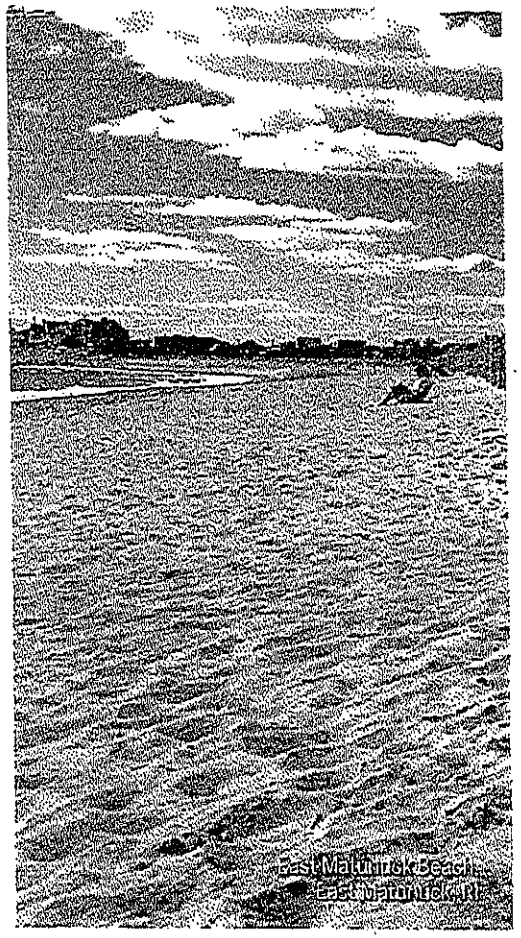
Blue Cross Blue Shield of Rhode Island

www.bcbsri.com

500 Exchange Street Providence, RI 02903-2699

Blue Cross Blue Shield of Rhode Island

2014 Retiree BlueCHiP for Medicare Group Preferred (HMO-POS) Plan Highlights



Here's an overview of premiums, copayments, and coinsurance costs for your plan option.

Questions?

To enroll or to learn more about how BlueCHiP for Medicare Group plans can help meet your healthcare needs, please call today: **1-800-505-2583. TTY/TDD: 711.** Our hours are: **October 1, 2013 - February 14, 2014:** Seven days a week, 8:00 a.m. to 8:00 p.m.; **February 15, 2014 - September 30, 2014:** Monday - Friday, ~~8:00 a.m. to 8:00 p.m.~~

Plan Features	BlueCHiP for Medicare Group Preferred (HMO-POS)
Monthly Premium	$232
Out-of-pocket Maximum[2]	$3,000
Copayments	
PCP office visits	$10
Specialist office visits	$30
Hospitalization	
Inpatient	$250 per admission per benefit period
Outpatient	20% coinsurance
Skilled nursing facility	Days 1-29: $0/day Days 30-100: $50/day
Diagnostic tests, X-rays, and lab services[3]	$0 for X-ray and lab services; $50/day for MRI/CT scan
DME/Home healthcare	$0
Emergency room	$65/visit
Ambulance	$50/day
Out-of-network Costs for Point-of-Service (POS) Option	20% coinsurance POS out-of-pocket maximum $3,000
Prescription Drugs[4]	You pay the following amounts until total yearly drug costs reach $2,850
Tier 1 (generic)	$6
Tier 2 (preferred brand)	$20
Tier 3 (non-preferred brand)	$50
Tier 4 (specialty tier)	25%
Catastrophic Coverage	After total out-of-pocket costs reach $4,550, you pay the greater of $2.55, $6.35, or 5% coinsurance.
Additional Benefits	
Living Fit	$5/month
Vision hardware	$70/year
Hearing aids	$500 every three years

You are covered for the following dental benefits. You must receive these services from one of our participating dentists. To get the most up-to-date information about participating providers, please visit BCBSRI.com.

Plan Features	Dental Benefits
Preventive Services	
Annual Exam	You pay nothing.
Cleanings	You pay nothing. Two cleanings per calendar year
X-rays	
Bitewing X-rays	You pay nothing. One set per calendar year
Full mouth set (one set every five years)	You pay nothing.
Individual X-rays	You pay nothing.
Comprehensive Services	
Includes fillings; simple extractions; minor treatment to relieve acute pain; oral surgery; root canal therapy; biopsies; and denture repairs	20%
Annual Benefit Maximum	$1,500

[1] You must have Medicare Part A and Medicare Part B to enroll. You must continue to pay your monthly Medicare Part B premiums.

[2] The out-of-pocket maximum includes only Medicare-covered services. This is the most you would pay for these services during a calendar year. You must receive all routine care from plan providers with the exception of emergencies, urgent care, ambulance, or dialysis. It may cost more to get care from out-of-network providers.

[3] Review may include but is not limited to preauthorization and/or continued treatment by the Plan and/or Plan designee.

[4] After your total yearly drug costs reach $2,850, BlueCHiP for Medicare Group Preferred covers all Tier 1 drugs at the applicable copayment and you pay 47.5% of the cost (plus the dispensing fee) on brand-name drugs until your yearly out-of-pocket drug costs reach $4,550, unless you are getting Extra Help.

EXHIBIT
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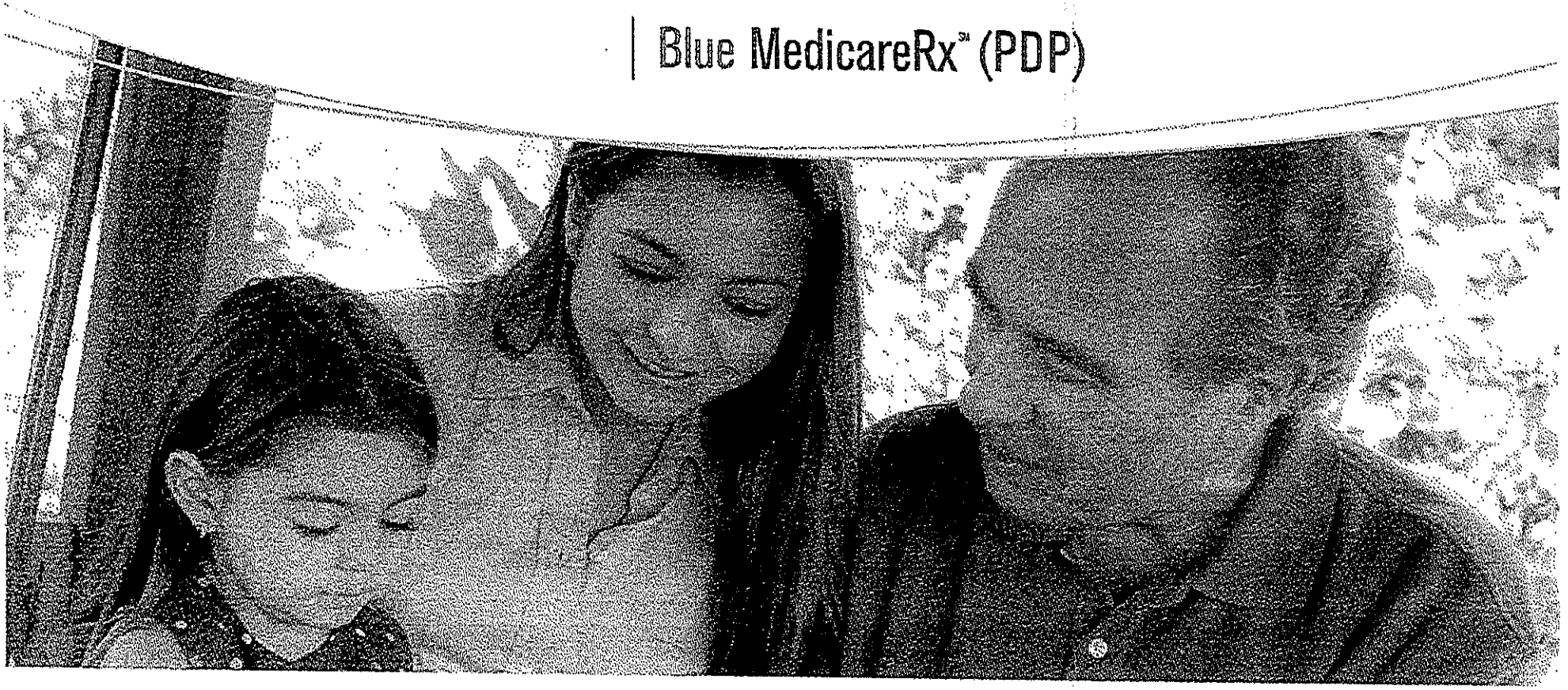
Blue Cross Blue Shield of Rhode Island

Blue MedicareRx℠ (PDP)



2014 Summary of Benefits
Blue MedicareRx℠ (PDP)

Group Prescription Drug Plan
$5 / $15 / $30

S2893_1327_082013_GRP

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Section I: Introduction

Introduction to the Summary of Benefits for Your Blue MedicareRx Plan

For January 1, 2014 - December 31, 2014

Thank you for your interest in Blue MedicareRx. Blue MedicareRx includes standard Medicare Part D benefits supplemented with coverage provided by your former employer/union health plan. Blue MedicareRx is referred throughout this Summary of Benefits as "plan" or "this plan."

This plan is offered by Blue Cross & Blue Shield of Rhode Island a Medicare Prescription Drug Plan that contracts with the Federal government.

This Summary of Benefits tells you some features of our plan. It doesn't list every drug we cover, every limitation, or exclusion. To get a complete list of our benefits, please call us and ask for the "Evidence of Coverage."

You Have Choices In Your Medicare Prescription Drug Coverage

You are being offered this plan as part of your former employer's retiree benefits. As a Medicare beneficiary, you can choose from different Medicare prescription drug coverage options. You can choose from Blue MedicareRx offered by your former employer, or an Individual (non-group) Medicare Prescription Drug Plan. Another option is to get your prescription drug coverage through an Individual (non-group) Medicare Advantage Plan (MA) that offers prescription drug coverage. If you enroll in an Individual (non-group) plan, you may not be eligible to enroll in your employer's retiree plan in the future. Please contact your former employer's group administrator for information on eligibility requirements for your retiree plan.

How Can I Compare My Options?

The chart in this booklet lists some important drug benefits. You can use this Summary of Benefits to compare the benefits offered by this plan to the benefits offered by other Medicare Prescription Drug Plans or Medicare Advantage Plans with prescription drug coverage.

Where Is This Plan Available?

As a member of your former employer's retiree plan, you may enroll in this plan as long as you live in the United States.

Who Is Eligible to Join?

You can join this plan if you are entitled to Medicare Part A and/or enrolled in Medicare Part B and live in the service area.

If you are enrolled in a MA coordinated care (HMO or PPO) plan or a MA private fee-for-service (MA PFFS) plan that includes Medicare prescription drugs, you may not enroll in a prescription drug plan (PDP) unless you disenroll from the HMO, PPO or MA PFFS plan.

Enrollees in a private fee-for-service (PFFS) plan that does not provide Medicare prescription drug coverage or a MA Medical Savings Account (MSA) plan may enroll in a PDP. Enrollees in an 1876 Cost plan may enroll in a PDP.

Where Can I Get My Prescriptions?

This plan has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We will not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases.

The pharmacies in our network can change at any time. You can ask for a Pharmacy Directory or visit us at **http://Groups.RxMedicarePlans.com**. Our Customer Care number is listed on the back cover of this booklet.

What If My Doctor Prescribes Less Than a Month's Supply?

In consultation with your doctor or pharmacist, you may receive less than a month's supply of certain drugs. Also, if you live in a long-term care facility, you will receive lessthan a month's supply of certain brand [and generic] drugs. Dispensing fewer drugs at a time can help reduce cost and waste in the Medicare Part D program, when this is medically appropriate.

The amount you pay in these circumstances will depend on whether you are responsible for paying coinsurance (a percentage of the cost of the drug) or a copay (a flat dollar amount for the drug). If you are responsible for coinsurance for the drug, you will continue to pay the applicable percentage of the drug cost. If you are responsible for a copay for the drug, a "daily cost-sharing rate" will be applied. If your doctor decides to continue the drug after a trial period, you should not pay more for a month's supply than you otherwise would have paid. Contact your plan if you have questions about cost-sharing when less than a one-month supply is dispensed.

Does My Plan Cover Medicare Part B or Part D Drugs?

This plan does not cover drugs that are covered under Medicare Part B as prescribed and dispensed. Generally, we only cover drugs, vaccines, biological products and medical supplies associated with the delivery of insulin that are covered under the Medicare Prescription Drug Benefit (Part D) and that are on our formulary.

What Is a Prescription Drug Formulary?

This plan uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a formulary to you and you can see our complete formulary on our website at **http://Groups.RxMedicarePlans.com.**

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

What Should I Do If I Have Other Insurance in Addition to Medicare?

If you also have a Medigap (Medicare Supplement) plan through your former employer, your Medigap plan benefits will work with your Medicare Part D Plan. If you have an Individual (non-group) Medigap policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare Prescription Drug Plan. If you decide to keep your current Medigap policy, your Medigap Issuer will remove the prescription drug coverage portion from your Medigap policy. This will occur as of the effective date of your Medicare Prescription Drug Plan coverage. Your Issuer will adjust your premium. Call your Medigap Issuer for details.

How Can I Get Extra Help With My Prescription Drug Plan Costs or Get Extra Help with Other Medicare Costs?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as your co-

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with other Medicare costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TTD users should call 1-877-486-2048, 24 hours a day, 7 days a week; and see http://www.medicare.gov "Programs for People with Limited Income and Resources" in the publication *Medicare & You.*
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office.

What Are My Protections in This Plan?

All Medicare Prescription Drug Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with the Medicare Prescription Drug Program. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Prescription Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of this plan, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

What Is a Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Blue MedicareRx for more details.

Section 2: Summary of Benefits

If you have any questions about this plan's benefits or costs, please contact Blue MedicareRx for details.

Prescription Drugs: *Drugs covered under your Medicare Part D Prescription Drug Plan*

The benefits described below are offered by Blue MedicareRx, a standard Medicare Part D plan supplemented with benefits provided by your former employer.

Blue MedicareRx Plan		
Initial Coverage Level		*You pay the following until your total yearly drug costs reach $2,850[1]:*
		30-day supply at a network **Retail** pharmacy
Tier 1	Generic Drugs	$5
Tier 2	Preferred Brand Drugs	$15
Tier 3	Non-Preferred Brand Drugs	$30
		90-day supply at a network **Retail** pharmacy[2]
Tier 1	Generic Drugs	$15
Tier 2	Preferred Brand Drugs	$45
Tier 3	Non-Preferred Brand Drugs	$90
		Not all drugs on Tiers 1 and 2 are available at this extended day supply. Please contact the plan for more information.
		90-day supply through network **Mail-Order** pharmacy
Tier 1	Generic Drugs	$5
Tier 2	Preferred Brand Drugs	$30
Tier 3	Non-Preferred Brand Drugs	$60
		Not all drugs on Tiers 1 and 2 are available at this extended day supply. Please contact the plan for more information.

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Blue MedicareRx Plan	
Coverage Gap	*After your total yearly drug costs reach $2,850, your former employer provides supplemental coverage that will keep your copayments and/or coinsurance as outlined above.* *Your copayments and/or coinsurance will not change until you qualify for Catastrophic Coverage.*
Catastrophic Coverage	*After your yearly out-of-pocket drug costs reach $4,550:*
Generics (including brand drugs treated as generic)	$2.55
All other drugs	$6.35

[1]All covered drugs are on the Blue MedicareRx formulary/drug list.

[2]Available at retail pharmacies that have agreed to allow members to fill 90-day supplies of their prescriptions.

General Information

In some cases, the plan requires you to first try one drug to treat your medical condition before they will cover another drug for that condition.

Certain prescription drugs will have maximum quantity limits.

Your provider must get prior authorization from Blue MedicareRx for certain prescription drugs.

Covered Part D drugs are available at out-of-network pharmacies in special circumstances, including illness while traveling outside of the plan's service area where there is no network pharmacy. Your copayment and/or coinsurance at out-of-network pharmacies is the same as at network pharmacies and depends on whether you purchase a Generic, Preferred Brand, Specialty or Non-Preferred Brand drug. However, if you go to an out-of-network pharmacy, you are responsible for the difference between the amount charged at the out-of-network pharmacy and what your plan would have paid at a network pharmacy.

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached year-to-date "total drug costs" of $2,850 and are not already receiving "Extra Help."

If you have reached year-to-date "total drug costs" of $2,850, your former employer provides supplemental coverage that will keep your copayments and/or coinsurance in the Coverage Gap the same as what you pay in the Initial Coverage Level. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs and move you through the Coverage Gap. The amount discounted by the manufacturer will count toward your out-of-pocket costs as if you had paid this amount. Your Explanation of Benefits (EOB) will show any discounted amount provided.

Once your out-of-pocket costs reach $4,550, you will move to the Catastrophic phase and the Medicare Coverage Gap Discount Program will no longer be applicable.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Care.

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Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-620-1748. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-620-1748. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-888-620-1748。我们的中文工作人员很乐意帮助您。这是一项免费服务。

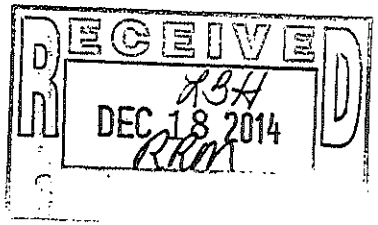
Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-888-620-1748。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-620-1748. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-620-1748. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-620-1748 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-620-1748. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.



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Multi-language Interpreter Services

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화1-888-620-1748 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-620-1748. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لديك. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-888-620-1748. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-620-1748 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-620-1748. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-620-1748. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-620-1748. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-620-1748. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-888-620-1748 にお電話ください。日本語を話す人 者 が支援いたします。 は無料のサービスです

The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan.

Limitations, copayments, and restrictions may apply.

Benefits, formulary, pharmacy network, premium and/or co-payments/co-insurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

Please call Blue MedicareRx for more information about our plan.

Visit us at Groups.RxMedicarePlans.com or, call us:

Customer Care Hours:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday

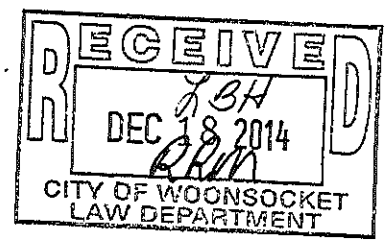
24 hours a day

Current members should call toll-free **1-888-620-1748**. (TTY/TDD **1-866-236-1069**)

Prospective members should call toll-free **1-800-505-2583**. (TTY/TDD **711**)

For more information about Medicare, please call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the web.

If you have special needs, this document may be available in other formats.



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Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

Anthem Insurance Companies, Inc., Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross & Blue Shield of Rhode Island, and Blue Cross and Blue Shield of Vermont are the legal entities which have contracted as a joint enterprise with the Centers for Medicare & Medicaid Services (CMS) and are the risk-bearing entities for Blue MedicareRx (PDP) plans. The joint enterprise is a Medicare-approved Part D Sponsor. Enrollment in Blue MedicareRx (PDP) depends on contract renewal.

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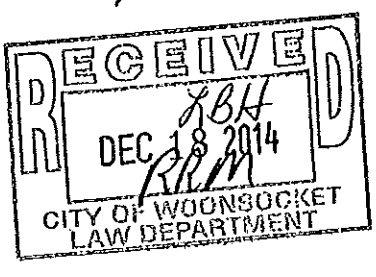

WOONSOCKET BUDGET COMMISSION RESOLUTION REGARDING TERMINATION AND REINSTATEMENT OF HEALTH INSURANCE FOR RETIREES

WHEREAS, by Resolution adopted on March 19, 2013, Amended Resolution adopted on June 28, 2013, and Second Amended Resolution adopted on July 29, 2013 (hereafter "Retiree Resolutions"), the Woonsocket Budget Commission ("Budget Commission") made changes to the health insurance coverage provided by the Woonsocket Education Department and the City of Woonsocket (hereafter collectively the "City") to those City retirees and their beneficiaries (hereafter "Retirees/Beneficiaries") who retired as of June 30, 2013;

WHEREAS, one mandated change is that Retirees/Beneficiaries make specified contributions to the cost of their health insurance;

WHEREAS, these contributions are an amount equivalent to a specified percentage of the applicable and current working rate, as established annually, and as set forth in paragraphs 2 through 6 in the Second Amended Retiree Resolution (July 29, 2013);

WHEREAS, the Budget Commission and the City implemented the Retiree Resolutions by, *inter alia*: issuing customized written notices to Retirees/Beneficiaries outlining the changes to their health insurance coverage; and by administering an open enrollment period allowing enrollment and election changes in response to the changes as mandated by the Retiree Resolutions;

WHEREAS, commencing in July 2013, the Budget Commission and the City continued the implementation of the Retiree Resolutions by issuing to each Retiree/Beneficiary in arrears written notices requesting payment of their applicable pro-rated annual contributions;

WHEREAS, the Budget Commission hereby seeks to notify Retirees/Beneficiaries of the process by which their health insurance coverage shall be terminated and reinstated at a future date; DLL 12/23/14

NOW, THEREFORE, BE IT RESOLVED BY THE WOONSOCKET BUDGET COMMISSION AS FOLLOWS:

1. Payments Due in Advance: The applicable pro-rated annual contribution shall be due in monthly installments, and must be paid to the City in advance by no later than the first (1st) day of each month (the "Due Date");

2. Termination of Coverage for Nonpayment: The Retirees/Beneficiaries shall at all times be obligated to notify the City promptly of any change in mailing address.

   a. First Notice: In the event that any Retiree/Beneficiary fails to make timely payment of his or her contribution, the City shall send written notice to the Retiree/Beneficiary at the last mailing address on file, demanding payment of the amount past due ("First Notice").

   b. Second Notice: If the Retiree/Beneficiary fails to make payment within one calendar month after the Due Date, and provided that the First Notice has been sent, the City shall send a second written notice to the Retiree/Beneficiary, stating that the insurance coverage of the Retiree/Beneficiary shall be terminated, effective on the date that is the 1st day of the second calendar month after the Due Date ("Second Notice").

   c. Termination Date: The insurance coverage of the Retiree/Beneficiary shall thereafter be terminated by the City, as provided in the Second Notice, unless the Retiree/Beneficiary tenders full payment to the City prior to the date of termination in an amount comprised of all of the following installments:

      i. the first installment which was the subject of the First Notice;

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ii. the next and second installment which came due during the notice period and/or all subsequent installments that came due during the notice period; and;

iii. the next applicable monthly installment, to be paid in advance as required under paragraph (1).

3. Reinstatement of Coverage after Termination for Nonpayment: In the event that the insurance coverage of a Retiree/Beneficiary is terminated in accordance with paragraph 2, the Retiree/Beneficiary shall thereafter and forever be deemed ineligible for insurance coverage through the City unless the Retiree/Beneficiary tenders full payment to the City as described in paragraph 2(c)(i), (ii), and (iii) above, and provided that the Retiree/Beneficiary remains otherwise eligible for health insurance coverage through the City.

4. Date of Reinstatement: The effective date of the reinstatement of coverage shall be determined as follows:

a. If the Retiree/Beneficiary experiences a Qualifying Event as defined by the insurance provider, the effective date shall be the first (1st) day of the first (1st) calendar month following the Qualifying Event; or

b. If the Retiree/Beneficiary does not experience a Qualifying Event as defined by the insurance provider, the effective date shall be the first (1st) day of the first (1st) calendar month following the close of the City's next open enrollment period, which shall take place annually.

5. Attachment 1 illustrates the process set forth in paragraphs 1-4, and shall be used as a guide in implementing those provisions.

6. Voluntary Termination of Coverage: Any Retiree/Beneficiary whose insurance coverage through the City was not terminated for non-payment, but who elected to terminate that coverage, and who thereafter seeks to enroll or re-enroll should the need arise, and who remains eligible for such coverage through the City, shall be allowed to enroll or re-enroll after a Qualifying Event or during open enrollment, whichever is applicable, as determined and defined by the insurance provider.

7. Resolution Inapplicable: Should any Retiree/Beneficiary fully execute an agreement with the Budget Commission, or with the Budget Commission, City of Woonsocket, and Woonsocket Education Department, which agreement provides specific terms for termination of health insurance coverage after nonpayment and/or reinstatement of coverage after termination for nonpayment, then this Resolution shall not apply to that Retiree/Beneficiary signatory; instead, the terms of said agreement shall control.

8. Effective Date: This Resolution shall be effective July 1, 2013 upon approval by the Woonsocket Budget Commission.

Dated: 9/23/13

By: Ilene Duteau

For the Woonsocket Budget Commission

12/23/14

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ATTACHMENT 1

The following hypothetical shall serve as a guide for implementation of provisions in the Woonsocket Budget Commission Resolution Regarding Termination and Reinstatement of Health Insurance for Retirees.

Termination: Let's assume that the Retiree fails to make payment of his or her monthly contribution to the annual cost of health insurance, as determined by the working rate established at the start of the fiscal year (which runs from July 1st through June 30th of the following year). In particular, let's assume that he or she misses the Due Date of May 1, 2014. The City shall send to the Retiree a:

1. First Notice requesting payment of the outstanding contribution, and if thereafter the Retiree still fails to make payment by June 1st, then a
2. Second Notice stating that the Retiree's coverage will be terminated effective July 1st.

If the Retiree Party thereafter fails to make 2 retroactive monthly payments by June 30th, for his or her contribution for each of May 2014 and June 2014, and 1 monthly payment by July 1st, for July 2014, then his or her health insurance through the City shall be terminated as of July 1, 2014.

Reinstatement: The City shall reinstate the Retiree's coverage if he or she remains otherwise eligible, conditioned upon one of two scenarios, as follows:

1. Qualifying Event: Let's assume that the Retiree whose health insurance has been terminated experiences a Qualifying Event in January 2015. That Retiree can be reinstated with coverage effective February 1, 2015, provided that he or she makes 2

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retroactive payments to the City on or before January 31, 2015, for his or her contribution for each of May 2014 and June 2014, and 1 monthly payment by February 1st for February 2015. The Retiree was not insured through the City for the months of July, August, September, October, November, December 2014, and January 2015.

2. No Qualifying Event: Let's assume that the Retiree whose health insurance has been terminated requests reinstatement in January 2015 but does not experience a Qualifying Event. The Retiree cannot be reinstated until after the next open enrollment period. Let's assume that the open enrollment period runs from May 15th through June 30th each year. The Retiree can be reinstated with coverage effective July 1, 2015, provided that he or she makes 2 retroactive payments to the City on or before June 30, 2015, for his or her contribution for each of May 2014 and June 2014, and 1 monthly payment by July 1st for July 2015. The Retiree was not insured through the City for the months of July, August, September, October, November, and December 2014, and for January, February, March, April, May, and June 2015.

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Rhode Island Department of Revenue
Office of the Director

December 17, 2014

To Whom It May Concern:

As the Director of the Rhode Island Department of Revenue, I am writing this Letter of Assurance, in support of members of the Association of Retired Firefighters ("Association"), who have reached a Memorandum of Agreement with the Woonsocket Budget Commission ("Commission") and the City of Woonsocket ("City") regarding changes to their pension and post-employment medical benefits. This Letter of Assurance is incorporated by reference into the Memorandum of Agreement as Exhibit I.

In May 2012, at the request of the Woonsocket City Council, I appointed the Commission because the fiscal crisis confronting the City had become so chronic and severe that it threatened the short and long-term welfare of its citizens. After taking various emergency measures, and after review of the City's finances, the Commission concluded that if nothing changed, the City would likely be required to file a petition under Chapter 9, Title 11, through a receiver appointed under R.I. Gen. Laws § 45-9-7. Municipal bankruptcy is a drastic measure, as the experience in Central Falls made plain. To avert insolvency and restore the City's fiscal stability, the Commission and City, through its agents, began work in earnest with the Department of Revenue to develop a five-year plan ("5-Year Plan"). As part of this 5-Year Plan, on March 19, 2013, the Commission enacted a Resolution that modified the pension and medical benefits of all retirees, Association members, effective July 1, 2013, "absent agreement to the contrary."

Since March 2013, the Association has negotiated in good faith with the Commission through its representatives, to identify ways that the Commission might amend the Resolution to provide concessions and alternatives that would benefit their constituents without compromising the 5-Year Plan. I personally have participated in these negotiations, and can say without hesitation that they have been cooperative, honorable and diligent throughout this process. The resulting Memorandum of Agreement is a fair compromise.

Despite all of the above efforts, it nonetheless may become necessary to appoint a receiver under R.I. Gen. Laws § 45-9-7, and thereafter to file a petition in the name of the City under Chapter 9, Title 11 of the United States Code. If that action results, and in support of the consideration by the Commission given in exchange for concessions by the Association as reflected in the Memorandum of Agreement, I hereby provide my full assurance as the Director of the Department of Revenue to support a recommendation to the receiver that the Memorandum of Agreement be controlling to the extent allowed by law. Moreover, it the receiver files a petition for bankruptcy, I will further support a recommendation that this Memorandum of Agreement become the "pendency plan" during the bankruptcy process that it be accepted as part of the "plan of debt adjustment," as those terms are defined in the applicable law and to the extent allowed by that law.

Sincerely,

RBG 12/23/14

Rosemary Booth Gallogly

Rosemary Booth Gallogly
Director, Rhode Island Department of Revenue

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CITY OF WOONSOCKET
LAW DEPARTMENT

One Capitol Hill, 1st Floor, Providence, RI 02908 | Tel. (401) 574-8999 Fax (401) 574-8997 TTY Relay via 711

AMENDMENT TO MEMORANDUM OF AGREEMENT BETWEEN THE CITY OF WOONSOCKET, BY AND THROUGH THE WOONSOCKET BUDGET COMMISSION, AND THE ASSOCIATION OF RETIRED WOONSOCKET FIREFIGHTERS ON BEHALF OF ITS RETIREE MEMBERS AND BENEFICIARIES

The Parties hereby execute this Amendment to the Memorandum of Agreement signed on December 18, 2014, by the City through its Mayor, the Honorable Lisa Baldelli-Hunt, and by the Retiree Parties, through Rene R. Menard, President of the Association of Retired Woonsocket Firefighters ("MOA"). The purpose of this Amendment is to ensure that the language in the MOA conforms to comparable provisions in the Memorandum of Agreement between the City of Woonsocket, by and through the Woonsocket Budget Commission, and the Fraternal Order of Police, Lodge #51, on Behalf of its Retiree Members and Beneficiaries. Except as set forth below, all provisions in the MOA shall be fully incorporated herein and remain unchanged and controlling:

1. Paragraph 2 on pages 5 through 6 shall be replaced with the language in italics below, which shall become paragraph 2 and subparagraphs 2(a) and 2(b), and subparagraphs (a) through (e) shall be renumbered subparagraphs (c) through (g):

   "Cost of Living Adjustment. Upon the effective date of this Memorandum of Agreement, the WBC shall adopt a Resolution directing as follows:

   a. *Within one-hundred-and-twenty (120) days of adoption of the Resolution, the City shall make a compounded two-percent (2%) cost-of-living adjustment payment to each eligible Pension Retiree (which does not include surviving spouses or any beneficiaries). The 2% adjustment shall be applied to the pension benefit that the Pension Retiree actually received as of July 1, 2014 and not the pension benefit that the Pension Retiree would have received had the cost-of-living adjustment*

not been suspended under the Retiree Reform Resolution (adopted on March 19, 2013), and shall be applicable to all pension benefit payments made in fiscal year 2015 (July 1, 2014 – June 30, 2015).

b. *Thereafter, the City shall pay to eligible Pension Retirees (which do not include surviving spouses or any beneficiaries), cost-of-living adjustments (hereinafter "COLA") in accordance with the following schedule:*

   i. *A compounded two (2%) percent COLA for fiscal year 2015 (effective July 1, 2014);*

   ii. *A compounded two (2%) percent COLA for fiscal year 2017 (effective July 1, 2016);*

   iii. *A compounded two (2%) percent COLA for fiscal year 2019 (effective July 1, 2018);*

   iv. *A compounded two (2%) percent COLA for fiscal year 2021 (effective July 1, 2020);*

   v. *A compounded two (2%) percent COLA for fiscal year 2023 (effective July 1, 2022);*

   vi. *and then for each fiscal year thereafter, subject to the subparagraphs (d) and (e) below."*

2. The first sentence in paragraph 9 shall be modified to reflect the following change indicated in italics: "Any Retiree Party who, as of the effective date of this Agreement, owes the City monies under paragraphs 5 through 8, after offset for any applicable overpayment made since July 1, 2014, shall make full payment to the City of the amount outstanding by no later than *one-hundred and twenty (120)* days after the effective date of

this Memorandum of Agreement; if he or she fails to make payment by that date, then the City shall terminate his or her medical insurance in accordance with the WBC Resolution Regarding Termination and Reinstatement of Health Insurance for Retirees, adopted on September 23, 2013 ("Resolution for Coverage Termination"), which is incorporated hereto as Exhibit H."

3. The phrase "from beginning of time," which appears in the tenth Recital on page 4, and in paragraph 12 on page 16, shall be replaced with the phrase *"since May 1, 2012."*
4. The following clause in italics shall be added to paragraph 13 on page 17: "*except that if the Retiree Parties are compelled by subpoena to appear in an administrative or judicial proceeding such appearance shall not constitute a violation of this provision.*"
5. The following clause in italics shall be added to paragraph 17 on page 18: "*and the United States and Rhode Island Constitutions.*"

The City of Woonsocket,
By: The Honorable Lisa Baldelli-Hunt, Mayor

Lisa Baldelli-Hunt Date: 12.23.14

The Woonsocket Budget Commission
By: Dina Dutremble, Chair

Dina Dutremble Date: 12/23/14

The Association of Retired Woonsocket Firefighters
On behalf of the Association and the Retiree Parties
Listed in Attachment 1
By: Rene R. Menard, President

R R Menard Date: 12-23-14

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LAW DEPARTMENT

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