Subscriber Agreement

Roger Williams University

Group # s 01002670-0001, 01002670-0002, 01002670-0003, 01002670-0004, 01002670-0005, 01002670-0007, 01002670-0008, 01002670-0009, 01002670-0010, 01002670-0011, 01002670-0012, 01002670-0013, 01002670-0014, 01002670-0015, 01002671-0001, 01002671-0002

BlueCHiP with Flex

SUMMARY OF MEDICAL BENEFITS

This is a summary of *y*our medical *benefits* under this *plan*. It includes information about *copayments*, *deductibles*, and *benefit limits*. This summary is intended to give you a general understanding of the medical coverage available under this *plan*. Please read Section 3.0 for a detailed description of coverage for each *covered healthcare service* and Section 4.0 for exclusions.

The amount you pay for *covered healthcare services* can differ based on the following:

- the service was provided in an *inpatient* or *outpatient* setting, in a *physician's* office, in your home, or from a pharmacy;
- the healthcare *provider* is from a *network provider* or *non-network provider*;
- a *deductible*, a *copayment*, or a *benefit limit* applies;
- you reached your *plan year maximum out-of-pocket expense*;
- there are exclusions from coverage that apply; or
- our *allowance* for a *covered healthcare service* is less than the amount of your *copayment* and *deductible* (if any). In this case, you will be responsible to pay up to our *allowance* when services are rendered by a *network provider*.

Flex Plan

Using your Flex *Plan*, you may seek care for many services from *non-network providers* or from *network providers* without a *referral* from your *PCP*. Once you use the Flex *Plan* option to receive *covered healthcare services*, all *covered healthcare services* associated with the episode of care (e.g., lab, x-ray, hospitalization) are subject to the terms of this Rider. Services which are not covered under the Flex *Plan* are noted in the Summary of Medical *Benefits*.

Network Provider Services

If you receive *covered healthcare services* from a *network provider*, the *provider* has agreed to accept our payment for *covered healthcare services* as payment in full, excluding your *copayments*, *deductible* (if any), and the difference between the *benefit limit* and our *allowance*, if any.

Non-network Provider Services

If you receive *covered healthcare services* from a *non-network provider*, you will be responsible for the *provider's charge*. The *deductible* and *maximum out-of-pocket expenses* are calculated based on the lower of our *allowance* or the *provider's charge*, unless special circumstances apply or otherwise specifically stated. For additional information about special circumstances and how we pay *non-network providers* please see Section 6.

Coordinated Care, Referrals, and Self-referrals

When it is necessary to see a specialist, a *network PCP* will coordinate a *referral* for you to seek care from a *network provider*. Only a *network PCP* can coordinate *referrals*. For example, if a *network PCP* refers you to a *network* specialist, that specialist may not refer you to another specialist or *provider*. In this case, you need to obtain another *referral* from a *network PCP* to seek care from the second specialist or other *provider*.

Except for self-*referrals* as indicated below, if you receive *covered healthcare services* without a *referral* from a *network PCP*, the services will not be covered even if you use a *network provider*. The *provider* may bill you for the services when a *referral* is not obtained.

Deductible/Maximum Out-of-Pocket Expense

Deductible; Maximum Out-of-Pocket Expense	

Summary of Medical Benefits

Covered Benefits - See Covered Healthcare Services for additional benefit limits and details.	Care Coordinated by Your Primary Care Provider and permitted Self-Referrals	Flex Plan
(*) Preauthorization may be required for this service or for certain services in the benefit category. Please see Preauthorization in Section 5 for more information.	You Pay	You Pay
Ambulance Services		
		primary care physician elf-referrals.
[redacted]	*deductible*	*primary care physician elf-referrals.*
Autism Services		

[redacted]

Covered Benefits - See Covered Healthcare Services for additional benefit limits and details.	

Covered Benefits - See Covered Healthcare Services for additional benefit limits and details.	Care Coordinated by Your Primary Care Provider and permitted Self-Referrals	Flex Plan
(*) Preauthorization may be required for this service or for certain services in the benefit category. Please see Preauthorization in Section 5 for more information.	You Pay	You Pay
		deductible
		deductible
	deductible	*deductible*

SECTION 1: INTRODUCTION

Required Referrals

All services rendered by *network providers* require a *network PCP referral* except for those services you receive from a *network PCP*, *emergency* services, and permitted self-referred services. You are responsible for getting the *referral* when receiving

losing weight;
accessing maternal health services, including doula services.

Care Coordination is a personalized service that is part of your existing healthcare coverage and is available at no additional cost to you. For more information, please call (401) 459-CARE (2273) or visit our website.

Disease Management
If you have a chronic condition such as asthma, coronary heart disease, diabetes, congestive heart failure, and/or chronic obstructive pulmonary disease, we're here to help. Our tools and information can help you manage *y*our condition and improve *y*our health. You may also be eligible to receive help through our care coordination program. This voluntary program is available at no additional cost you. To learn more about disease management, please call (401) 459-5683 or 1-888-725-8500.

About This Agreement

Our entire contract with you consists of this *agreement* and our contract with *y*our employer. *Y*our ID card will identify you as a *member* when you receive the healthcare services covered under this *agreement*. By presenting *y*our ID card to receive *covered healthcare services*, you are agreeing to abide by the rules and obligations of this *agreement*

SECTION 2: ELIGIBILITY

This section describes:

- who is eligible for coverage;
- when coverage begins;
- how to add or remove family members;
- when coverage ends; and
- continuation of coverage.

Who Is an Eligible Person

You

You are eligible for coverage if you are an employee and have met *y*our employer's eligibility requirements, including any waiting period.

Your Spouse

If your *plan* includes family coverage*,* your spouse is eligible to enroll for healthcare coverage if you have selected a family *plan*. Only one of the following individuals may be enrolled at a given time:

- *Y*our legal spouse: according to the laws of the state in which you were married.
- *Y*our common law spouse: according to the law of the state in which *y*our marriage was formed. To be eligible, you and *y*our common law spouse need to complete our Affidavit of Common Law Marriage and provide us with the required documentation listed on the affidavit. Please call our Customer Service Department to obtain a copy.
- *Y*our civil union partner: according to the law of the state in which you entered into a civil union. Civil Union partners may only be enrolled if civil unions are recognized by the state in which you reside.
- Former Spouse: In the event of a divorce, *y*our former spouse may continue to be eligible for coverage provided that *y*our divorce decree requires it in accordance with state law. *Y*our former spouse will remain eligible on *y*our policy until the earlier of:
  - the date either you or your former spouse are remarried;
  - the date provided by the judgment of divorce; or
  - the date *y*our former spo72 Tm4 /Sp as0000912 0 612 792 re 99.48 490.48 Tm 0 G [(sp)6(ou

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sixty (60) days following the change in eligibility. Coverage will begin on the first day of the month following our receipt of your application.

In addition, you may be eligible for a Special Enrollment Period if you provide required information within thirty (30) days of one of the following events:

- you or your dependent lose minimum essential coverage (unless that loss of coverage is due to non-payment of premium or your voluntary termination of coverage);
- you adequately demonstrate to us that another health *plan* substantially violated a material provision of its contract with you;
- you make a permanent move to Rhode Island: or
- your enrollment or non-enrollment in a qualified health *plan* is unintentional, inadvertent, or erroneous and is the result of error, misrepresentation, or inaction by us or an agent of *HSRI* or the U.S. Department of Health and Human Services (HHS).

Coverage for Members Who Are Hospitalized on Their Effective Date

If you are in the *hospital* on *y*our effective date of coverage, healthcare services related to such hospitalization are covered as long as: (a) you notify us of *y*our hospitalization within forty-eight (48) hours of the effective date, or as soon as is reasonably possible; and (b) *covered healthcare services* are received in accordance with the terms, conditions, exclusions and limitations of this *agreement*. As always, *benefits* paid in such situations are subject to the Coordination of *Benefits* provisions.

How to Add or Remove Coverage for Family Members

If your *plan* offers family coverage, you must notify your employer if you want to add or remove family members according to the Special Enrollment provisions described above. When adding or removing a family member, inform your employer in advance of the requested effective date and your employer will notify us. All requests must be made through your employer. We cannot directly add or remove coverage for you or your family members.

When Your Coverage Ends

Coverage under this *plan* is guaranteed renewable. It can only be canceled by us for the following reasons:

- if you leave *y*our place of employment;
- if you decide to discontinue coverage. Inform your employer prior to the requested date of cancellation and your employer will notify us. If we do not receive your notice prior to the requested date of cancellation, you or your employer may be responsible for paying another month's premium;
- if the required premium is not paid within one month of the due date. We will mail you a notice of discontinuance along with information about enrolling in an individual healthcare

if *y*our employer contracts with another insurer or entity to provide or administer *benefits* for the *covered healthcare services* provided by this *agreement*;
if fraud is determined by us. See Rescission of Coverage section below for additional details;

If *y*our healthcare coverage is terminated for one of the reasons listed above, we will send you a termination notice thirty (30) days before the termination date. The notice will indicate the reason why *y*our healthcare coverage has ended.

When your coverage ends, you may apply for individual healthcare coverage directly from BCBSRI or through *HSRI*. You must meet the eligibility requirements and we must receive required enrollment information within sixty (60) days from the date your group coverage ended along with required premium. If you do not reside in Rhode Island, you are not eligible to enroll in an individual *plan* from BCBSRI or *HSRI*. You may be able to obtain coverage through an insurance company in the state in which you reside.

Rescission of Coverage
Rescission is a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation is not a rescission if it:

only has a prospective effect (as described above); or
is due to non-payment of premiums, which can have a retroactive cancellation effect.

We may rescind *y*our coverage if you or *y*our dependents commit fraud. Fraud includes, but is not limited to, intentional misuse of *y*our identification card (ID card) or intentional misrepresentation of a material fact. Any *benefit* paid in the past will be voided. You will be responsible to reimburse us for all costs and *claims* paid by us. We must provide you a written notice of a rescission at least thirty (30) days in advance.

Except for non-payment, we will not contest this policy after it has been in force for a period of two (2) years from the later of the effective date of this *agreement* or the latest reinstatement date.

Continuation of Coverage

If *y*our coverage is terminated, you may be eligible to continue *y*our coverage in accordance with state or federal law.

Continuation of Coverage According to State Law
In accordance with R.I. General Laws § 27-19.1, if *y*our employment is terminated due to one of the following reason, *y*our healthcare coverage may be continued, provided that you continue to pay the applicable premiums.

Involuntary layoff or death;
The workplace ceasing to exist; or
Permanent reduction in size of the workforce.

The period of this continuation will be for up to eighteen (18) months from *y*our termination date, but not to exceed the period of continuous employment preceding

termination with *y*our employer. The continuation period will end for any person covered under *y*our policy on the date the person becomes employed by another group and is eligible for *benefits* under that group's *plan*.

Extended Benefits

If you are disabled on the date *y*our healthcare coverage ends, *y*our *benefits* will be temporarily e[BT /F1 12 Tf 1 0 0 1 431.68 653.2 Tm 0 g 0 G [( )] TJ ET Q q 0.00000912 2q 0(s)]

SECTION 3: COVERED HEALTHCARE SERVICES

This section describes *covered healthcare services*. This *plan* covers services only if they meet all of the following requirements:

Listed as a *covered healthcare service* in this section. The fact that a *provider* has prescribed or recommended a service, or that it is the only available treatment for an illness or injury does not mean it is a *covered healthcare service*

Ambulance Services

Ground Ambulance

This *plan* covers local professional or municipal ground ambulance services when it is *medically necessary* to use these services, rather than any other form of transportation as required under R.I. General Law § 27-20-55. Examples include but are not limited to the following:

- from a *hospital* to a home, a skilled nursing facility, or a rehabilitation facility after being discharged as an *inpatient*;
- to the closest available *hospital emergency* room in an *emergency* situation; or
- from a *physician's* office to an *emergency* room.

Our *allowance* for ground ambulance includes the services rendered by an *emergency* medical technician or paramedic, as well as any drugs, supplies and cardiac monitoring provided.

Air and Water Ambulance

This *plan* covers air and water ambulance services when:

- the time needed to move a patient by land, or the instability of transportation by land, may threaten a patient's condition or survival; or
- if the proper equipment needed to treat the patient is not available from a ground ambulance.

The patient must be transported to the nearest facility where the required services can be performed and the type of *physician* needed to treat the patient's condition is available.

Our *allowance* for the air or water ambulance includes the services rendered by an *emergency* medical technician or paramedic, as well as any drugs, supplies and cardiac monitoring provided.

Autism Services

This *plan* covers the following services for the treatment of autism spectrum disorders in accordance with R.I. General Law § 27-20-11.

Applied behavior analysis when provided and/or supervised by an individual licensed by the state in which the service is rendered. See the Summary of Medical *Benefits* for the amount that you pay.

Physical therapy, occupational therapy, and speech therapy services when rendered as part of the treatment of autism spectrum disorder. A *benefit limit* will not apply to these services.

Psychological and psychiatric services, and prescription drugs are also covered. See Behavioral Health Services and Prescription Drug and Diabetic Equipment or Supplies for additional information.

Coverage for autism spectrum disorders does not affect any obligation of a school district, a state or other governmental entity to provide services to an individual under an individualized family service *plan*, an individualized education program, or similar services required under state or federal law. Services related to autism that are furnished by school personnel are not covered under this *plan*.

Behavioral Health Services

Behavioral health services include the evaluation, management, and treatment for a mental health or *substance use disorder* condition.

used as a step down from a higher level of care; or
used a step-up from standard care level of care.

Intermediate care services include the following:

Partial Hospital Program (PHP) – PHPs are structured and medically supervised day, evening, or nighttime treatment *programs* providing individualized treatment plans. A PHP typically runs for five hours a day, five days per week.

Intensive Outpatient Program (IOP) – An IOP provides substantial clinical support for patients who are either in transition from a higher level of care or at risk for admission to a higher level of care. An IOP typically runs for three hours per day, three days per week.

Home and Community Based Adult Intensive Service (AIS) and Child and Family Intensive Treatment (CFIT) – AIS/CFIT *programs* offer services primarily based in the home and community for qualifying adults and children with moderate-to-severe mental health conditions. These *programs* consist at a minimum of ongoing *emergency*/crisis evaluations, psychiatric assessment, medication evaluation and management, case management, psychiatric nursing services, and individual, group, and family therapy.

Cardiac Rehabilitation

This *plan*

DME includes supplies necessary for the effective use of the equipment.

This *plan* covers the following DME:

- wheelchairs, *hospital* beds, and other DME items used only for medical treatment; and
- replacement of purchased equipment which is needed due to a change in *y*our medical condition or if the device is not functional, no longer under warranty, or cannot be repaired.

DME may be classified as a rental item or a purchased item. In most cases, this *plan* only pays for a rental DME up to our *allowance* for a purchased DME. Repairs and supplies for rental DME are included in the rental *allowance*.

Preauthorization may be required for certain DME and replacement or repairs of DME.

Medical Supplies

Medical supplies are consumable supplies that are disposable and not intended for re-use. Medical supplies require an order by a *physician* and must be essential for the care or treatment of an illness, injury, or congenital defect.

Covered medical supplies include:

- essential accessories such as hoses, tubes and mouthpieces for use with *medically necessary* DME (these accessories are included as part of the rental *allowance* for rented DME);
- catheters, colostomy and ileostomy supplies, irrigation trays and surgical dressings; and
- respiratory therapy equipment.

Diabetic Equipment and Supplies

This *plan* covers diabetic equipment and supplies for the treatment of diabetes in accordance with R.I. General Law §27-20-30. Covered diabetic equipment and supplies include:

- therapeutic or molded shoes and inserts for custom-molded shoes for the prevention of amputation;
- blood glucose monitors including those with special features for the legally blind, external insulin infusion pumps and accessories, insulin infusion devices and injection aids; and
- lancets and test strips for glucose monitors including those with special features for the legally blind, and infusion sets for external insulin pumps.

The amount you pay differs based on whether the equipment and supplies are bought from a durable medical equipment *provider* or from a pharmacy. See the Summary of Pharmacy *Benefits* and the Summary of Medical *Benefits* for details. Coverage for some diabetic equipment and supplies may only be available from either a DME *provider* or from a *pharmacy*. Visit our website to determine if this is applicable or call our Customer Service Department.

Prosthetic Devices
Prosthetic devices replace or substitute all or part of an internal body part, including contiguous tissue, or replace all or part of the function of a permanently inoperative or malfunctioning body part and alleviate functional loss or impairment due to an illness, injury or congenital defect

Hair Prosthesis (Wigs)
This *plan* covers hair prosthetics (wigs) worn for hair loss suffered as a result of cancer treatment in accordance with R.I. General Law § 27-20-54 and subject to the *benefit limit* and *copayment* listed in the Summary of Medical *Benefits*.

This *plan* will reimburse the lesser of the *providerôs charge* or the *benefit limit* shown in the Summary of Medical *Benefits*. If the *providerôs charge* is more than the *benefit limit*, you are responsible for paying any difference.

Early Intervention Services (EIS)

This *plan* covers Early Intervention Services in accordance with R.I. General Law §27-20-50. Early Intervention Services are educational, developmental, health, and social services provided to children from birth to thirty-six (36) months. The child must be certified by the Rhode Island Department of Human Services (DHS) to enroll in an approved Early Intervention Services *program*. Services must be provided by a licensed Early Intervention *provider* and rendered to a Rhode Island resident.

Members not living in Rhode Island may seek services from the state in which they reside; however, those services are not covered under this *plan*.

Early Intervention Services as defined by DHS include but are not limited to the following:

- speech and language therapy;
- physical and occupational therapy;
- evaluation;
- case management;
- nutrition;
- service plan development and review;
- nursing services; and
- assistive technology services and devices.

Education - Asthma

This *plan* covers asthma education services when the services are prescribed by a *physician* and performed by a certified asthma educator.

Emergency Room Services

This *plan* covers services received in a *hospital*

Off-label Prescription Drugs

This *plan* covers off label prescription drugs for cancer or disabling or life-threatening chronic disease if the prescription drug is recognized as a treatment for cancer or disabling or life-threatening chronic disease in accepted medical literature, in accordance with R.I. General Law § 27-55-1.

Gender Affirming Services

This *plan* covers gender affirming services. *Preauthorization* may be required for gender affirming surgical services.

Hearing Services

Hearing Exams and Tests

This *plan* covers hearing exams and diagnostic hearing tests.

Hearing Aids

This *plan* covers hearing aids in accordance with R.I. General Law § 27-20-46, subject to the *benefit limit* and *copayments* listed in the Summary of Medical *Benefits*.

We will reimburse the lesser of the *provider's charge* or the *benefit limit* shown in the Summary of Medical *Benefits*. If the *provider's charge* is more than the *benefit limit*, you are responsible for paying any difference. See Section 6 for additional information.

Home Health Care

This *plan* covers the following home care services when provided by a certified home healthcare agency:

- nursing services;
- services of a home health aide;
- visits from a social worker;
- medical supplies; and
- physical, occupational and speech therapy.

Hospice Care

If you have a terminal illness and you agree with *y*our *physician* not to continue with a curative treatment *program*, this *plan* covers hospice care services received in *y*our home, in a skilled nursing facility, or in an *inpatient* facility.

Human Leukocyte Antigen Testing

This *plan* covers human leukocyte antigen testing for A, B, and DR antigens once per *member* per lifetime to establish a *member's* bone marrow transplantation donor suitability in accordance with R.I. General Law §27-20-36.

The testing must be performed in a facility that is:

- accredited by the American Association of Blood Banks or its successors; and
- licensed under the Clinical Laboratory Improvement Act as it may be amended from time to time.

At the time of testing, the person being tested must complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor *program*.

Infertility Services

This *plan* covers the following services, in accordance with R.I. General Law §27-20-20.

Services for the diagnosis and treatment of infertility if you are:
- a presumably healthy individual; and
- unable to conceive or sustain a pregnancy during a:
  one (1) year period for a member under age 35;
  six (6) month period for a member age 35 or older.

Standard fertility preservation services for members not in active infertility treatment when a medically necessary medical treatment may directly or indirectly cause iatrogenic infertility. Iatrogenic infertility means an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

Prescription drugs for the treatment of infertility. Coverage is based on the route of administration and site of service. For information about prescription drugs see Prescription Drugs and Diabetic Equipment or Supplies and the Summary of Pharmacy *Benefits*.

Preauthorization may be required for certain infertility services.

Infusion Therapy

This *plan* covers infusion therapy and related administration services.

Inpatient Services

Hospital

This *plan* covers services provided while *inpatient* in a general or *specialty hospital* including, but not limited to the following:

anesthesia;
diagnostic tests and lab services;
dialysis;
drugs;
intensive care/coronary care;
nursing care;
physical, occupational,8n9smig09ilq 0.00000912 0 62 Tf 1 0 0 1 96.66 170.66 Tm 0 G [(hysical,

Notify us if you are admitted from the *emergency* room to a *hospital* that is not in our *network*. Our Customer Service Department can assist you with any questions you may have about *y*our coverage.

Rehabilitation Facility
This *plan* covers rehabilitation services received in a *general hospital* or *specialty hospital*. Coverage is limited to the number of days shown in the Summary of Medical *Benefits*.

Physician Visits
This *plan* covers the services of a *physician* or other *provider* in charge of *y*our medical care while you are *inpatient* in a general or *specialty hospital*.

Mastectomy Services

Inpatient
This *plan* provides coverage for a minimum of forty-eight (48) hours in a *hospital* following a mastectomy and a minimum of twenty-four (24) hours in a *hospital* following an axillary node dissection. Any decision to shorten these minimum coverages shall be made by the attending *physician* in consultation with and upon agreement with you. If you participate in an early discharge, defined as *inpatient* care following a mastectomy that is less than forty-eight (48) hours and *inpatient* care following an axillary node dissection that is less than twenty-four (24) hours, coverage shall include a minimum of

another area of the *hospital* or licensed healthcare facility. See the Summary of Medical *Benefits* for the amount you pay.

Office Visits (other than Preventive Care Services)

This *plan* covers office and clinic visits to diagnose or treat a sickness or injury. Office visit *copayments* differ depending on the type of *provider* you see and

services that have an A or B rating in the current recommendations of the U.S. Preventative Services Task Force (USPSTF);
immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
preventive care and screenings for infants, children, and adolescents as outlined in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); or
preventive care and screenings for women as outlined in the comprehensive guidelines as supported by HRSA.

Covered early detection services, *preventive care services* and adult and pediatric immunizations or vaccinations

vaccine. If a covered immunization is provided as part of an office visit, the office visit *copayment* and *deductible* (if any) will apply.

Travel immunizations are covered to the extent that such immunizations are recommended for adults and children by the Centers for Disease Control and Prevention (CDC). The recommendations are subject to change by the CDC.

Preventive Screening/Early Detection Services
This *plan* covers preventive screenings based on the ACA guidelines noted above. Preventive screenings include but are not limited to:

mammograms;
pap smears;
prostate-specific antigen (PSA) tests;
flexible sigmoidoscopy;

double contrast barium enema;
fecal occult blood tests, screening for gestational diabetes, and human papillomavirus; and
genetic counseling for breast cancer susceptibility gene (BRCA).

This *plan* covers colonoscopies in accordance with R.I. General Laws § 27-18-58. *Covered healthcare services* include an initial colonoscopy or other medical tests or procedures for colorectal cancer screening and a follow-up colonoscopy if the results of the initial test are abnormal.

Contraceptive Methods and Sterilization Procedures for Women
This *plan* covers the following contraceptive services:

FDA approved contraceptive drugs and devices requiring a prescription;
barrier method (cervical cap, diaphragm, or implantable) fitted and supplied during an office visit; and
surgical and sterilization services for women with reproductive capacity, including but not limited to tubal ligation.

Breastfeeding Counseling and Equipment

Private Duty Nursing Services

This *plan*

Labs and Pathology
Diagnostic labs and pathology include but are not limited to:

- blood tests,
- urinalysis,
- pap smears, and
- throat cultures.

For tests, labs and imaging associated with *Preventive Care Services* and Early Detection Services, please refer to that section, and see the Summary of Medical *Benefits* for the amount you pay.

Lyme Disease Diagnosis and Treatment
This *plan* covers diagnostic testing and long-term antibiotic treatment of chronic lyme disease in accordance with R.I. General Law § 27-20-48. To be covered, services must be ordered by *y*our *physician* after evaluation of *y*our symptoms, diagnostic test results, and response to treatment. Coverage for lyme disease treatment will not be denied solely because such treatment may be characterized as unproven, experimental, or investigational.

Urgent Care

This *ental, or*

- o alveolectomy including curettage of osteitis or sequestrectomy;
- o alveoloplasty, each quadrant;
- o complete surgical removal of inaccessible impacted mandibular tooth mesial surface;
- o excision of feberous tuberosities;
- o excision of hyperplastic alveolar mucosa, each quadrant;
- o operculectomy excision periocoronal tissues;
- o removal of partially bony impacted tooth;
- o removal of completely bony impacted tooth, with or without unusual surgical complications;
- o surgical removal of partial bony impaction;
- o surgical removal of impacted maxillary tooth;
- o surgical removal of residual tooth roots; and
- o vestibuloplasty with skin/mucosal graft and lowering the floor of the mouth.

Dialysis Services

The following dialysis services received in *y*our home:

- o installing or modifying of electric power, water and sanitary disposal or *charges* for these services;
- o moving expenses for relocating the machine;
- o installation expenses not necessary to operate the machine; and
- o training in the operation of the dialysis machine when the training in the operation of the dialysis machine is billed as a separate service.

Repair or replacement of DME when the equipment is under warranty, covered by the manufacturer, or during the rental period.

Infant formula, nutritional supplements and food, or food products, whether or not prescribed, unless required by R.I. Law §27-20-56 for Enteral Nutrition Products, or delivered through a feeding tube as the sole source of nutrition.

Corrective or orthopedic shoes and orthotic devices used in connection with footwear, unless for the treatment of diabetes.

Experimental or Investigational Services

Treatments, procedures, facilities, equipment, drugs, devices, supplies, or services that are *experimental or investigational* except as described in Section 3.

Gender Affirming Services

Reversal of gender affirming surgery.

Hearing Services

Repairs, modifications, cords, batteries, and other assistive listening devices.

Home Health Care

Homemaking, companion, chronic, or custodial care services.

Services of a personal care attendant.

Infertility Services

Freezing, storage and thawing of embryos, sperm, or other tissues, for future use, unless the freezing, storage and thawing is needed due to potential iatrogenic infertility as described in Infertility Services in Section 3.

Reversal of voluntary sterilization or infertility treatment for a person that previously had a voluntary sterilization procedure.

Fees associated with finding an egg

Pregnancy and Maternity Services

Preimplantation genetic diagnosis, also known as embryo screening.
Amniocentesis or any other service when performed solely to determine gender.
Services related to surrogate parenting or the newborn child of the surrogate parent, when the surrogate is not a *member* of this *plan*.

Prescription Drugs and Diabetic Equipment or Supplies

Biological products for allergen immunotherapy and vaccinations.
Blood fractions.
Compound prescription drugs that are not made up of at least one *legend drug*.
Bulk powders and chemicals used in compound prescriptions that are not FDA approved, are not covered unless listed on our *formulary*.
Prescription drugs prescribed or dispensed outside of our dispensing guidelines.
Prescription drugs ordered or prescribed based solely on online questionnaires, telephonic interviews, surveys, emails, or any other marketing solicitation methods, whether alone or in combination.
Prescription drugs that have not proven effective according to the FDA.
Prescription drugs used for cosmetic purposes.
Prescription drugs purchased from a non-designated pharmacy, if a pharmacy has been designated for you through the Pharmacy Home Assignment program.
Experimental prescription drugs including those placed on notice of opportunity hearing status by the Federal Drug Efficacy Study Implementation (DESI).
Prescription drugs provided to you that are not dispensed by a *network pharmacy* or covered under *y*our medical *plan*.
Prescription drugs and diabetic equipment and supplies purchased at a *non-network pharmacy* unless indicated as covered in the Summary of Pharmacy *Benefits*.
Prescription drug related medical supplies except for diabetic, regardless of the reason prescribed, the intended use, or *medical necessity*. Examples include, but are not limited to, alcohol pads, bandages, wraps or pill holders.
Off-label use of prescription drugs except as described in *Experimental or Investigational* Services in Section 3;
Prescribed weight-loss drugs.
Replacement of prescription drugs resulting from a lost, stolen, broken or destroyed prescription order or refill.
Therapeutic devices and appliances, including hypodermic needles and syringes except when used to administer insulin.
Vitamins, unless specifically listed as a *covered healthcare service*.
A prescription drug refill greater than the refill number authorized by *y*our *physician*, more than a year from the date of the original prescription, or limited by law.
Long-acting opioids and other controlled substances, nicotine replacement therapy, and *specialty prescription drugs* when purchased from a mail order pharmacy.
Prescription drugs and *specialty prescription drugs* when the required prescription drug *preauthorization* is not obtained.
Certain prescription drugs that have an over-the-counter (OTC) equivalent.

Services and supplies used for *y*our personal appearance and/or comfort, whether or not prescribed by a *physician* and regardless of *y*our condition. These services

SECTION 5: REQUESTS FOR AUTHORIZATION, DENIALS, COMPLAINTS, AND APPEALS

Requests for Authorization

We evaluate the *medical necessity* of select *covered healthcare services* using clinical criteria to facilitate clinically appropriate, cost-effective management of *y*our care. This process is called *utilization review*, and it can occur in the following situations:

- When you (or *y*our *provider*) request authorization for a service before receiving it (*preauthorization*).
- When you (or your *provider*) request authorization for a service that is already initiated or ongoing (concurrent authorization).
- When you (or *y*our *provider*) request authorization for a service you have already received (retrospective authorization).

The determination of whether a service is *medically necessary* is solely for the purpose of *claims* payment and the administration of health *benefits* under this *plan*. It is not an exercise of professional medical judgment. BCBSRI does not act as a healthcare *provider*. We do not furnish medical care. You are not prohibited from having a treatment or hospitalization for which reimbursement was not authorized. Nothing here will change or affect *y*our relationship with *y*our *provider(s)*.

We may contract with an organization to conduct *utilization review* on our behalf. If another company does *utilization review* on our behalf, the company will act as an independent contractor and is not a partner, agent, or employee of BCBSRI.

Preauthorization

Preauthorization is the process by which we determine whether a *covered healthcare service* is *medically necessary* before you receive the service. Medical services which may require *preauthorization* are marked with an asterisk (*) in the Summary of Medical *Benefits*. Pharmacy services which require prescription drug *preauthorization* are marked with the (+) symbol in the Summary of Pharmacy *Benefits*.

Preauthorization is not a guarantee of payment, as the process does not take other coverage requirements into account, such as *benefit limits*, the amount you pay, or eligibility.

In most cases, *providers* are responsible for obtaining *preauthorization* for *covered healthcare services*. However, in some cases you are responsible for ensuring a *preauthorization* has been obtained prior to receiving *a covered healthcare service*. Please check with your *provider* for assistance with obtaining the *preauthorization*. The chart below describes who is responsible for ensuring a *preauthorization* has been obtained:

Retrospective Authorization
We review requests for retrospective authorization when services were provided before authorization was obtained. A notification of the retrospective determination will be provided within thirty (30) calendar days from receipt of the request. You have the right to appeal our determination or to take legal action as described in this section.

Network Authorization
For services that cannot be provided by a *network provider*

within forty-

action under section 502(a) of ERISA after you have exhausted all appeals available under the *plan*. That means, for both medical and administrative appeals, federal law requires that you pursue a final decision from the *plan*, prior to filing suit under section 502(a) of ERISA. For a medical appeal, that final decision is the determination of the appeal. You are not required to submit *y*our *claim* to external review prior to filing a suit under section 502(a) of ERISA. Consult *y*our employer to determine whether this applies to you and what *y*our rights and obligations may be. If you are dissatisfied with the decision on *y*our *claim*, and have complied with applicable state and federal law, you are entitled to seek judicial review. This review will take place in an appropriate court of law.

SECTION 6: CLAIM FILING AND PROVIDER PAYMENTS

This section provides information regarding how a *member* may file a *claim* for a *covered healthcare service and how* we pay *providers* for a *covered healthcare service*.

How to File a Claim

Network providers file *claims* on *y*our behalf.

Non-network providers may or may not file *claims* on *y*our behalf. If a *non-network provider* does not file a *claim* on *y*our behalf, you will need to file it yourself. To file a *claim*, please send us the *provider's* itemized bill, and include the following information:

- *y*our name;
- *y*our *member* ID number;
- the name, address, and telephone number of the *provider* who performed the service;
- date and description of the service; and
- *charge* for that service.

Please send *y*our *claim* to the address listed in the Contact Information section.

Claims must be filed within one calendar year of the date you receive a *covered healthcare service*. *Claims* submitted after this deadline are not eligible for reimbursement. This timeframe does not apply if you are legally incapacitated.

How Network Providers Are Paid

We pay *network providers* directly for *covered healthcare services*. *Network providers* agree not to bill, *charge*, collect a deposit from, or seek reimbursement from you for a *covered healthcare service*, except for your share under the *plan*.

When you see a *network provider*, you are responsible for a share of the cost of *covered healthcare services*. Your share includes the *deductible*, if one applies, and the *copayment*, as listed in the Summary of Medical *Benefits*. The *covered healthcare service* may also have a *benefit limit*, which caps the amount we will reimburse the *provider* for that service. You will be responsible for any amount over the *benefit limit*, up to the *allowance*.

Your *provider* may request these payments at the time of service, or may bill you after the service. If you do not pay your *provider*, the *provider* may decline to provide current or future services or may pursue payment from you, such as beginning collection4(in)3(e t)-2(o provide

will not be adjusted based on these alternative payment methods, or for any payment that is not calculated on an individual claim basis. Our contracts with *providers* may establish a payment *allowance* for multiple *covered healthcare services*, and we may apply a single *copayment* based on these arrangements. In these cases, you will typically be responsible for fewer *copayments* than if your share of the cost had been determined on a per service basis.

How Non-network Providers Are Paid

Except in the special circumstances described below, if you receive care from a *non-network provider*, you are responsible for paying all *charges* for the services you received. You may submit a *claim* for reimbursement of the payments you made.

We reimburse *non-network provider* services using the same guidelines we use to pay *network providers*. Generally, our payment for *non-network provider* services will not be more than the amount we pay for *network provider* services. If an *allowance* for a specific *covered healthcare service* cannot be determined by reference to a fee schedule, reimbursement will be based upon a calculation that reasonably represents the amount paid to *network providers*.

When *covered healthcare services* are received from a *non-network provider*, we reimburse you or the *non-network provider*, less any *copayments* and *deductibles,* based on:

- the lesser of:
  - our *allowance*;
  - the *non-network provider's charge*; or
  - the *benefit limit*; or
- federal or state law, when applicable.

You are responsible for the *deductible*, if one applies, and the *copayment*, as well as any amount over the *benefit limit* that applies to the service you received.

You are responsible for the difference between the amount that the *non-network provider* bills and the payment we make. Generally, we send reimbursement to you, but we reserve the right to reimburse a *non-network provider* BT P law

Emergency room services (which may include post-stabilization services unless the *non-network provider* determines that you are able to travel using nonmedical transportation or nonemergency medical transportation and obtains your consent in writing before rendering the services)
Urgent care services
Ground ambulance services
Air ambulance services;
We specifically approve the use of a *non-network provider* for *covered healthcare services,* see *Network Authorization* in Section 5 for details;
Non-emergency covered healthcare services rendered by a *non-network provider* at certain *network* facilities*****, unless the non-network provider obtains your consent in writing before rendering the service;

- For the following circumstances, the *network* level of *benefits* will apply, regardless of whether the non-network provider had obtained that consent:
  - there is no *network provider* available in the *network* facility;
  - the services are furnished as the result of unforeseen or urgent medical needs arising at the time the non-emergency covered healthcare services are furnished:
  - the services are ancillary, such that you would not typically select the *provider* (including, but not limited to, any service relating to emergency medicine, anesthesiology, pathology, radiology, neonatology, diagnostic testing, and those services provided by assistant surgeons, hospitalists, and intensivists).

Otherwise, as required by law.

*****For purposes of this section only, certain *network* facilities are: *general hospital*, *general hospital outpatient* department, critical access hospital, and ambulatory surgical center.

Special Circumstances Where Balance Billing From the Non-Network Provider is Prohibited:

In accordance with federal law, when you receive *covered healthcare services* for the limited circumstances listed below, we pay the *non-network provider* directly for those services. The *non-network provider* cannot bill you for the difference between the *non-network provider charges* and the payment we made, known as balance billing. You are responsible for the *network copayment* and *deductible*, if one applies, which will be cT /F8t096.3 245B plies, which will

Non-*emergency covered healthcare services* rendered by a *non-network provider* at certain *network* facilities***** unless the *non-network provider* obtains your consent in writing before rendering the services.

BlueCard® Program
Under the *BlueCard*® Program, when you receive *covered healthcare services* within the geographic area served by a Host Blue, BCBSRI will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating *providers*.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees
Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, we will include any such surcharge, tax or other fee as part of the *claim* charge passed on to you.

Nonparticipating Providers Outside Our Service Area

Enrolled Member Liability Calculation
When *covered healthcare services* are provided outside of BCBSRI service area by nonparticipating *providers*, the amount an enrolled

These factors make up the order of *benefit* determination rules, described in greater detail below:

(1) Non-dependent/Dependent
If you are covered under a *plan* and you are the main *subscriber*, the *benefits* of that *plan* will be determined before the *benefits* of a *plan* that covers you as a dependent. If, however, you are a Medicare beneficiary, then, in some instances, Medicare will be *secondary* and the *plan*, which covers you as the main *subscriber* or as a dependent, will be primary.408] TJ248] TJS

If one of *y*our dependents covered under this *plan* is a student, and has additional coverage through a student *plan*, then the *benefits* from the student *plan* will be determined before the *benefits* under this *plan*.

(2) Dependent Child
If dependent children are covered under separate *plans* of more than one person, whether a parent or guardian, *benefits* for the child will be determined in the following order:
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amount. The amount of payments made includes the reasonable cash value of any *benefits* provided in the form of services.

Our Right of Subrogation and/or Reimbursement

Subrogation

You may have a legal right to recover some or all of the costs of *y*our health care from someone else called a third party. Third party means any person or company that is, or could be, responsible for the costs of injuries or illness to you or any other dependent. This includes such costs to you or any other dependent covered under this *plan*.

If we pay for costs a third party is responsible for, we reserve the right to recover up to the full amount we paid. Our rights of recovery apply to any payment made to you or due to you from any source. This includes, but is not limited to:

- payment made or due by a third party;
- payments made or due by any insurance company on behalf of the third party;
- any payments or rewards made or due under an uninsured or underinsured motorist coverage policy;
- any disability award or settlement payment made or due;
- medical coverage payments made or due under any automobile policy;
- premises or homeowners' medical coverage payments made or due;
- premises or homeowners' insurance coverage; and
- any other payments made or due from a source intended to compensate you for third party injuries.

We have the right to recover those payments made for *covered healthcare services*. We can do this with or without *y*our consent. Our right has priority, except as otherwise provided by law. We can recover against the total amount of any recovery, regardless of whether all or part of the recovery is for medical expenses or the recovery is less than the amount needed to reimburse you fully for the illness or injury.

We may contract with a third party or subrogation agent to administer subrogation recoveries.

Reimbursement

In addition to the subrogation rights described above, we also have reimbursement rights. If you recover money by lawsuit, settlement, or otherwise, we may seek reimbursement from you for *covered healthcare services* for which we paid or will pay. Our reimbursement right applies when you received payment from a third party for *covered healthcare services* we provided under this *plan*, as described in the subrogation section above.

We can seek from you reimbursement up to the amount of any payment made to you, whether

- all or part of the payment to you was designated, allocated, or characterized as payment for medical expenses; or
- the payment is for an amount less than that necessary to compensate you fully for the illness or injury.

We may offset future payments under this *plan* until we have been paid an amount equal to what you were paid by a third party for the cost of the *covered healthcare services* that we paid or will pay. If we pay legal fees to recover money from you, we can recover those costs from you as well. The amount you must pay us cannot be reduced by any legal costs you have paid.

If you receive money in a settlement or a judgment and do not agree with our right to reimbursement, you must keep an amount equal to our *claim* in a separate account until the dispute is resolved. If a court orders that money be paid to you or any third party before *y*our lawsuit is resolved, you must tell us, at that time, so we can respond in court.

Member Cooperation
You further agree:

SECTION 8: GLOSSARY

When a defined term is used, it will be *italicized*.

***AGREEMENT* (*SUBSCRIBER AGREEMENT*)** means this document. It is a legal contract between you and BCBSRI.

ALLOWANCE is the amount a *network provider* has agreed to accept for a *covered healthcare service* based on an agreed upon fee schedule. For information about how we pay for healthcare services outside of our service area, please see How *BlueCard Providers* Are Paid: Coverage for Services Provided Outside of the Service Area in Section 6.

When you receive *covered healthcare services* from a *network provider*, the *provider* has agreed to accept our payment for *covered healthcare services* as payment in full. You will be responsible to pay your *copayments*, *deductibles* (if any), and the difference between the *benefit limit* and our *allowance*, if any.

When you receive *covered healthcare services* from a *non-network provider*, our reimbursement to you or our payment to the *non-network provider*, less any *copayments* and *deductibles,* will be based on:

the lesser of our *allowance*, the *non-network provider's charge*, or the *benefit limit*: or federal or state law, when applicable.

CHARGES means the amount billed by any healthcare *provider* (e.g., *hospital*, *physician*, laboratory, etc.) for *covered healthcare services* without the application of any discount or negotiated fee arrangement.

CLAIM means a request that *benefits* of a *plan* be provided or paid.

COPAYMENT means either a defined dollar amount or a percentage of our *allowance* that you must pay for certain *covered healthcare services*.

COVERED HEALTHCARE SERVICES means any service, treatment, procedure, facility, equipment, drug, device, or supply that we have reviewed and determined is eligible for reimbursement under this *plan*.

DEDUCTIBLE means the amount that you must pay each *plan year* before we begin to pay for certain *covered healthcare services*. See the Summary of Medical *Benefits* for *y*our *plan year deductible, benefit limits* and to determine which services are subject to the *deductible*.

DEVELOPMENTAL SERVICES means therapies, typically provided by a qualified

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RESIDENTIAL TREATMENT FACILITY means a facility which provides a treatment *program* for behavioral health services and is established and operated in accordance with applicable state laws for residential treatment *programs*.

RETAIL CLINIC is a medical clinic licensed to provide limited services, generally located in a retail store, supermarket or pharmacy. A *retail clinic* provides vaccinations and treats uncomplicated minor illnesses such as colds, ear infections, minor wounds or abrasions.

SOUND NATURAL TEETH means teeth that:

are free of active or chronic clinical decay;

have at least fifty percent (

SECTION 9: CONTACT INFORMATION

SECTION 10: NOTICES AND DISCLOSURES

Behavioral HealthCare Parity

This *plan* provides parity in *benefits* for behavioral health services. This means that coverage of *benefits* for mental health and *substance* use *disorders* is generally comparable to, and not more restrictive than, the *benefits* for physical health.

Financial requirements, such as *deductibles*, *copayments*, or *benefit limits* that may apply to a behavioral health service *benefit* category, such as *inpatient* services, are not more restrictive than those that apply to most medical *benefits* within the same category.

Different levels of financial requirements to different tiers of prescription drugs are applied without regard to whether a prescription drug is generally prescribed for physical, mental health, or *substance* use *disorders*.

Other requirements, that are not expressed numerically, are applied to behavioral health services in comparable ways as medical *benefits*. Such requirements may include medical management standards, formulary design, *network* tier design or standards for *provider* admission into a *network*.

Genetic Information

This *plan* does not limit *y*our cove pequirements may include

healthcare operations;
case management and *utilization review*;
coordination of healthcare coverage; and
health oversight activities.

Our release of information about you is regulated by law. Please see the Rhode Island Confidentiality of HealthCare Communications and Information Act, R.I. Gen. Laws §§ 5-37.3-1 et seq. the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act, and implementing regulations, 45 C.F.R. §§ 160.101 et seq. (collectively "HIPAA"), the Gramm-Leach-Bliley Financial Modernization Act, 15 U.S.C. §§ 6801-6908, the Rhode Island Office of the Health Insurance Commissioner (OHIC) Regulation 100.

Protection Act

Under federal law, group health *plans* and health insurance issuers offering group healthcare coverage generally may not restrict *benefits* for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the *plan* or issuer may pay for a shorter stay if the attending *provider* (e.g., *y*our *physician*, nurse midwife, or *physician* assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, *plans* and issuers may not set the level of *benefits* or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a *plan* or issuer may not, under federal law, require that a *physician* or other healthcare *provider* obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

In accordance with R.I. General Law §27-20-17.1, this *plan* covers a minimum *inpatient hospital* stay of forty-eight (48) hours from the time of a vaginal delivery and ninety-six (96) hours from the time of a cesarean delivery:

if the delivery occurs in a *hospital*, the *hospital* length of stay for the mother or newborn child begins at the time of delivery (or in the case of multiple births, at the time of the last delivery).

if the delivery occurs outside a *hospital*, the *hospital* length of stay begins at the time the mother or newborn child is admitted to a *hospital* following childbirth.

Decisions to shorten *hospital* stays shall be made by the attending *physician* in consultation with and upon agreement with you. In those instances where you and your newborn child participate in an early discharge, you will be eligible for:

up to two (2) home care visits by a skilled, specially trained registered nurse for you and/or *y*our newborn child, (any additional visits may be reviewed for *medical necessity*); and

a pediatric office visit within twenty-four (24) hours after discharge from the *hospital*.

SECTION 11: PRESCRIPTION DRUG BENEFITS

The Summary of Pharmacy *Benefits* only applies to prescription drugs purchased at a retail, mail order, or specialty, pharmacy. For information about our pharmacy *network*, visit our website or call our Customer Service Department.

Required Preauthorization

Prescription drugs for which *preauthorization* is required are marked with the symbol (+) in the Summary of Pharmacy *Benefits*.

For details on how to obtain prescription drug *preauthorization*, see *Preauthorization* in Section 5 for details. If *preauthorization* is not obtained, you will be required to pay for the prescription drug at the pharmacy. You can ask us to consider reimbursement after you receive the prescription drug by following the prescription drug *preauthorization* process. For a list of prescription drugs that require *preauthorization*

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Covered Benefits	Network Pharmacy	Non-network Pharmacy
(+) Preauthorization is required for this service. Please see Preauthorization in Section 5 for more information.	You Pay	You Pay
Infertility Prescription Drugs -		

Prescription Drugs

This *plan* covers prescription drugs and diabetic equipment or supplies. When they are purchased from a pharmacy, prescription drugs and diabetic equipment or supplies are covered as a pharmacy *benefit*. When the prescription drug requires administration by a *provider* other than a pharmacist (or the FDA approved recommendation is administration by a *provider* other than a pharmacist), the prescription drug is covered as a medical *benefit* referred to as "*medical prescription drugs*".

Please see Pharmacy *Benefits* subsection A and Medical *Benefits* subsection B below for information about how these prescription drugs are covered.

Prescription drugs and diabetic equipment or supplies are covered when dispensed using the following guidelines:

the prescription must be *medically necessary*, consistent with the *physician's* diagnosis, ordered by a *physician* whose license allows him or her to order it, filled at a pharmacy whose license allows such a prescription to be filled, and filled according to state and federal laws;

the prescription must consist of *legend drugs* that require a *physician's* prescription under law, or compound medications made up of at least one *legend drug* requiring a *physician's* prescription under law;

the prescription must be dispensed at the proper place of service as determined by our

Prescription Drug Coverage Exception Process
When a prescription drug is not covered, you can request that this *plan* cover the drug as an exception.

To request a coverage exception, complete a Coverage Exception

Mail order pharmacies. These dispense maintenance and non-maintenance prescription drugs and diabetic equipment or supplies.
Specialty pharmacies. These dispense *specialty prescription drugs*, defined as such on our *formulary*.

For information about our *network* retail, mail order, and specialty pharmacies, visit our website or call our Customer Service Department.

These *medical prescription drugs* include, but are not limited to, medications administered by infusion, injection, or inhalation, as well as nasal, topical or transdermal administered medications. For some of these *medical prescription drugs*, the cost of the prescription drug is included in the *allowance* for the medical service being provided, and is not separately reimbursed.

English: If you, or someone you're helping, has questions about Blue Cross & Blue Shield of Rhode Island, you have the right to get help and information in your language at no cost. To talk

Spanish:

Portuguese:

Chinese:

French Creole:

Cambodian-Mon-Khmer:

French:

Italian:

Laotian:

Blue Cross & Blue Shield of Rhode Island, [illegible] 1-800-639-2227.

Arabic:

Russian:

Vietnamese:

Kru:

Ibo:

Yoruba:

Polish:

Korean:

Tagalog:

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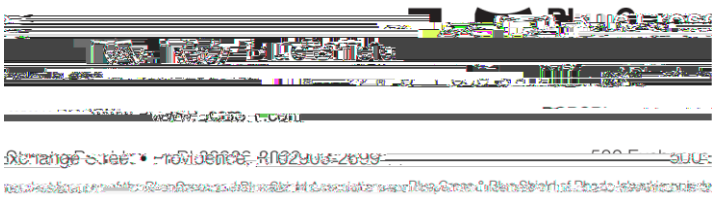

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