BLUE CROSS & BLUE SHIELD OF RHODE ISLAND
SUBSCRIBER AGREEMENT

TABLE OF CONTENTS

SUMMARY OF MEDICAL BENEFITS

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*ûs 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;
- the *network provider* has a Standard or Enhanced *benefit* designation;
- 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*.

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.

This *plan* uses the Blue Choice New England *provider network*. Our service area for *network providers* includes Rhode Island, Connecticut, Maine, Massachusetts, and New Hampshire.

When you receive healthcare services or supplies from a *network provider* in a state other than Rhode Island, *y*our coverage and other requirements for healthcare services may be different

s*sode Island

Permitted Self-referrals:

You may self-refer to the following *network providers* for *covered healthcare services*:

Behavioral Health Services;
Chiropractic Medicine Services;
Early Intervention Services*;
Emergency Care (emergency room services, ambulance services, and urgent care centers);
Hair Prosthetics (Wigs)*;
Hearing Aids*;
Obstetricians and Gynecologists;
Oncologists - Office Visits (consultation or second opinion; all other services require a *referral*);
Optometrists and Ophthalmologists;
Oral Surgery;
PCPs;
Retail Clinics;
Speech Therapy Services; and
Telemedicine services when rendered by our designated telemedicine *provider*, *PCPs,* or applicable services provided by specialists identified on this self-referral list.

***** You may self-refer to a *non-network provider* for *covered healthcare services* for Early Intervention Services, Hair Prosthetics, and Hearing Aids.

If a change is made to this self-*referral* list during your *plan year* period, BCBSRI will notify you of the change at least sixty (60) days before the change becomes effective.

Summary of Medical Benefits

Covered Benefits - See Covered Healthcare Services for additional benefit limits and details.	Network Providers	Non-network Providers
(*) 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		
Ground	$50	The level of coverage is the same as *network provider*.
Air/water*	$50	The level of coverage is the same as *network provider*.
Autism Services		

Covered Benefits - See Covered Healthcare Services for additional benefit limits and details.	Network Providers	Non-network Providers
(*) 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
Dialysis Services		
*Inpatient/outpatient/*in your home	0% - After *deductible*	20% - After *deductible*
Durable Medical Equipment (DME), Medical Supplies, Diabetic Supplies, Prosthetic Devices, and Enteral Formula or Food, Hair Prosthetics		
Outpatient durable medical equipment* - Must be provided by a licensed medical supply provider.	20% - After *deductible*	40% - After *deductible*
Outpatient medical supplies* - Must be provided by a licensed medical supply provider.	20% - After *deductible*	

Covered Benefits - See Covered Healthcare Services for additional benefit limits and details.	Network Providers	Non-network Providers
(*) 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
Inpatient Services		
General hospital or *specialty hospital* services* - unlimited days	0% - After *deductible*	20% - After *deductible*
Rehabilitation facility services* - limited to 45 days per *plan year.*	0% -	

Covered Benefits - See Covered Healthcare Services for additional benefit limits and details.	Network Providers	Non-network Providers
(*) 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
Prevention Care Services and Early Detection Services		
See Prevention and Early Detection Services section for details.	0%	20% - After *deductible*
Private Duty Nursing Services*		
Must be performed by a certified home health care agency.	0% - After *deductible*	20% - After *deductible*
Radiation Therapy/Chemotherapy Services		
Outpatient		

Your Member Identification Card

*Y*our BCBSRI *member* ID card is *y*our key to getting healthcare coverage. It shows *y*our healthcare *provider* that you're part of the nation's most trusted health *plan*. All BCBSRI *members* receive ID cards, which provide important information about *y*our coverage. This card is for identification only, and you must show it whenever you receive healthcare services. Please note you must be a current *member* to receive covered services.

Tips for keeping *y*our card safe:

Carry it with you at all times.

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 services from a *network provider*. If you receive services from a *network provider* without a *referral* or from a *non-network provider*, your *copayment* and *deductible* will be higher. See the Summary of Medical *Benefits* for details. You may be responsible to pay a *non-network provider* up to *charge*.

Programs to Keep You Healthy

Many health problems can be prevented by making positive changes to *y*our lifestyle, including exercising regularly, eating a healthy diet, and not smoking. As a *member*, you can take advantage of our wellness programs at no additional cost.

Wellness Programs

losing weight;
accessing maternal health services, includinth

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).

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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* under this *plan*.
Medically necessary, consistent with our medical policies and related guidelines at the time the services are provided.
Not listed in Exclusions Section.
Received while a *member* is enrolled in the *plan*.
Consistent with applicable state or federal law.
Provided with a *referral* from *y*our *PCP*. This requirement does not apply to *emergency* services, self-*referral* services and other exceptions as described in the Summary of Medical *Benefits*.

When you receive healthcare services or supplies from a *network provider* in a state other than Rhode Island, *y*our coverage and other requirements for healthcare services may be different from those described in this *agreement*. In this case, you may be entitled to receive additional coverage under this health *plan* as required by that state's law. You should call our customer service office for more help if this applies to you.

We review *medical necessity* in accordance with our medical policies and related guidelines. Our medical policies can be found on our website.

Our medical policies are written to help administer *benefits* for the purpose of *claims* payment. They are made available to you

Psychological and psychiatric services, and prescription drugs

Intermediate Care Services

This *plan* covers intermediate care services, which are facility-based *programs* that are:

more intensive than traditional *outpatient* services;
less intensive than 24-hour *inpatient hospital* or *residential treatment facility* services; and
used as a step down from a higher level of care; or
used a step-up from standard care level of care.

Durable Medical Equipment (DME), Medical Supplies, Prosthetic Devices, Enteral Formula or Food, and Hair Prosthesis (Wigs)

This *plan* covers durable medical equipment and supplies, prosthetic devices and enteral formula or food as described in this section.

Durable Medical Equipment (DME)

DME is equipment which:

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose;
- is not useful to a person in the absence of an illness or injury; and
- is for use in the home.

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 [illegible]

inherited diseases of amino acids and organic acids.

Food products modified to be low protein are covered for the treatment of inherited diseases of amino acids and organic acids. *Preauthorization* may be required.

Emergency Room Services

This *plan* covers services received in a *hospital emergency* room or an *independent freestanding emergency department* when needed to stabilize or initiate treatment in an *emergency*. If your condition needs immediate or urgent, but non-*emergency* care, contact your *PCP* or use an *urgent care center*.

This *plan* covers bandages, crutches, canes, collars, and other supplies incidental to your treatment in the *emergency* room as part of our *allowance* for the *emergency* room services.

Additional services provided in the *emergency* room or an *independent freestanding emergency department* such as radiology or *physician* consultations are covered separately from *emergency* room services and may require additional *copayments*. The amount you pay is based on the type of service being rendered.

Follow-up care services, such as suture removal, fracture care or wound care, received at the *emergency* room will require an additional *emergency* room *copayment*. Follow-up care services can be obtained from *y*our *primary care provider* or a specialist.

See Dental Services in Section 3 for information regarding *emergency* dental care services.

Experimental or Investigational Services

This *plan* covers certain *experimental or investigational* services as described in this section.

Clinical Trials

This *plan* covers clinical trials as required under R.I. General Law § 27-20-60. An approved clinical trial is a phase I, phase II, phase III, or phase IV clinical trial that is being performed to prevent, detect or treat cancer or a life-threatening disease or condition. In order to qualify, the clinical trial must be:

- federally funded;
- conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or
- a drug trial that is exempt from having such an investigational new drug application.

To qualify to participate in a clinical trial:

- you must be determined to be eligible, according to the trial protocol;
- a *network provider* must have concluded that *y*our participation would be appropriate; and
- medical and scientific information must have been provided establishing that *y*our participation in the clinical trial would be appropriate.

If a *network provider* is participating in a clinical trial, and the trial is being conducted in the state in which you reside, you may be required to participate in the trial through the *network provider*.

drugs;
intensive care/coronary care;
nursing care;
physical, occupational, speech and respiratory therapies;
physician's services while hospitalized;
radiation therapy;
surgery related services; and
room and board.

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*.

Blue Distinction Centers for Transplants℠ call our Customer Service Department or visit our website.

When the recipient is a covered *member* under this *plan*, the following services are also covered:

- obtaining donated organs (including removal from a cadaver);
- donor medical and surgical expenses related to obtaining the organ

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Preventive Care and Early Detection Services

This *plan* covers, early detection services, *preventive care services*, and immunizations or vaccinations in accordance with state and federal law, including the Affordable Care Act (

Vaccinations/Immunizations

This *plan* covers adult and pediatric preventive vaccinations and immunizations in accordance with current guidelines. Our *allowance* includes the administration and the 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

Private Duty Nursing Services

This *plan* covers private duty nursing services, received in *y*our home when ordered by a *physician*, and performed by a certified home healthcare agency. This *plan* covers these services when the patient requires continuous skilled nursing observation and intervention.

Radiation Therapy/Chemotherapy Services

This *plan* covers chemotherapy and radiation services.

Respiratory Therapy

This *plan* covers respiratory therapy services. When respiratory services are provided in *y*our home, as part of a home care *program*, durable medical equipment, supplies, and oxygen are covered as a durable medical equipment service.

Skilled Care in a Nursing Facility

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 *plan* covers services received at an *urgent care center*. For other services, such as surgery or diagnostic tests, the amount that you pay is based on the type of service being provided. See

SECTION 4: EXCLUSIONS

This section lists the services or categories of services that are not covered (excluded) under this *plan*. We will not cover services listed in this section even if they are prescribed or recommended by *y*our *provider*. We will not cover services that are not *medically necessary*, whether or not they are listed in this section.

The exclusion headings in this section are intended to group together services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath each heading.

- 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.

Dialysis services received in a *physician*ôs office.

Durable Medical Equipment (DME), Medical Supplies, Prosthetic Devices, Enteral Formula or Food, and Hair Prosthesis (Wigs)

Items typically found in the home that do not need a prescription and are easily

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

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.

Prescription drugs, therapeutic equivalents, or any other pharmaceuticals used to treat sexual dysfunctions.

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.
Prescriptions filled through an internet pharmacy that is not a verified internet pharmacy practice site certified by the National Association of Boards of Pharmacy.
Illegal drugs

Procedures to correct visual acuity including but not limited to cornea surgery or lens implants.
Removal of asymptomatic benign skin lesions.
Repeated cauterizations or electrofulguration methods used to remove growths on the skin.
Rhinoplasty.
Rhytidectomy.
Scar revision, regardless of symptoms.
Sclerotherapy for spider veins.
Skin tag removal.
Subcutaneous injection of filling material.
Suction assisted Lipectomy.
Tattooing or tattoo removal except tattooing of the nipple/areola related to a mastectomy.
Treatment of vitiligo.
Standby services of an assistant surgeon or anesthesiologist.
Orthodontic services related to orthognathic surgery.
Cosmetic procedures when performed primarily:

- to refine or reshape body structures or dental structures that are not functionally impaired;
- to improve appearance or self-esteem; or
- for other psychological, psychiatric or emotional reasons.

– Drugs, biological products, *hospital charges*, pathology, radiology fees and *charges* for surgeons, assistant surgeons, attending *physicians* and any other incidental services, which are related to cosmetic surgery.

Tests, Labs, and Imaging and X-rays (diagnostic)

Re-reading of diagnostic tests by a second *provider*.
Dental x-rays except when ordered by a *physician*/*dentist* to diagnose a condition due to an accident to *y*our *sound natural teeth*.
Over the counter diagnostic devices or kits even if prescribed by a *physician*, except for those devices or kits related to the treatment of diabetes or nicotine lab tests.
Parental testing.
Forensic testing.

Therapies

Acupuncture and acupuncturist services, including x-ray and laboratory services.
Biofeedback, biofeedback training, and biofeedback by any other modality for any condition.
Recreational therapy services and *programs*, including wilderness *programs*.
Services provided in any covered *program* that are recreational therapy services, including wilderness *programs*, educational services, complimentary services, non-medical self-care, self-help *programs*, or non-clinical services. Examples include, but are not limited to, Tai Chi, yoga, personal training, meditation.
Computer/internet/social media-based services and/or *programs*.

Maintenance therapy services unless it is a *habilitative service* that helps a person keep, learn or improve skills and functioning for daily living.
Aromatherapy.
Hippotherapy.
Massage therapy rendered by a massage therapist.
Therapies, procedures, and services for the purpose of relieving stress.
Physical, occupational, speech, or respiratory therapy provided in *y*our home, unless through a home care *program*.
Pelvic floor electrical and magnetic stimulation, and pelvic floor exercises.
Educational classes and services for speech impairments that are self-correcting.
Speech therapy services related to food aversion or texture disorders.
Exercise therapy.
Naturopathic, homeopathic, and Christian Science services, regardless of who orders or provides the services.

Vision Care Services

Eye exercises and visual training services, including computer-based vision training.
Lenses and/or frames and contact lenses unless specifically listed as a *covered healthcare service*.

Providers

Services performed by a *provider* who has been excluded or debarred from participation in federal programs, such as Medicare and Medicaid. To determine whether a *provider* has been excluded from a federal program, visit the U.S. Department of Human Services Office of Inspector General website (https://exclusions.oig.hhs.gov/) or the Excluded Parties List System website maintained by the U.S. General Services Administration (https://www.sam.gov/).
Services provided by facilities, *dentists*, *physicians*, surgeons, or other *providers* who are not legally qualified or licensed, according to relevant sections of Rhode Island Law or other governing bodies, or who have not met our credentialing requirements.
Services provided by a *non-network provider*, unless listed as covered in the Summary of Medical *Benefits*.
Services provided by naturopaths, homeopaths, or Christian Science practitioners.

Services Available or Provided from Other Sources

Services for any condition, illness

Services if another entity or agency is responsible under state or federal laws, which are provided for the health of schoolchildren or children with disabilities. See Title 16, Chapters 21, 24, 25, and 26 of the R.I. General Laws. See also applicable regulations about the health of schoolchildren and the special education of children with disabilities or similar rules set forth by federal law or state law of applicable jurisdiction.

All Other Exclusions

Services not approved by the FDA or other governing body.

Services we have not reviewed or we have not determined are eligible for coverage.

Services obtained through fraud or intentional misrepresentation.

Administrative service *charges* for:

- missed appointments;
- completion of *claim* forms;
- additional fees, sometimes referred to as access fees, associated with concierge, boutique, or retainer practices; and
- any other administrative *charges*.

Blood services for drawing, processing, or storage of *y*our own blood, including any penalty fees related to blood services.

Continuation of a *covered healthcare service* or *benefit* as a result of a clerical error.

Custodial care, rest care, day care, or non-skilled care services.

Convalescent homes, nursing homes including non-skilled care, assisted living facilities, or other residential facilities.

Educational classes, unless listed as covered, and training services.

Exams or services that are required for or related to employment, education, marriage, adoption, insurance purposes, court order, or similar third parties when not *medically necessary* or when the *benefit limit* for the exam or service has been met.

Routine foot care, including the treatment of corns, bunions except capsular or bone surgery, calluses, the trimming of nails, the treatment of simple ingrown nails and other preventive hygienic procedures, except when performed to treat *members* with a systemic condition such as metabolic, neurologic, or peripheral vascular disease.

Treatment of flat feet unless the treatment is a covered surgical service.

Telephone consultations, telephone services, or medication monitoring by phone, except for clinically appropriate telemedicine services as described in Section 3.

Healthcare services for work-related illnesses or injuries for which *benefits* are available under Workers' Compensation, whether or not you are entitled to such *benefits*, unless:

- you are self-employed, a sole stockholder of a corporation, or a member of a partnership; and
- your illnesses or injuries were incurred in the course of your self-employment, sole stockholder, or partnership activities; and
- you are not enrolled as an employee under a group health *plan* sponsored by another employer.

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 and supplies include, but are not limited to:

- batteries, unless indicated as covered;
- radio;
- telephone;
- television;
- air conditioner;
- humidifier;
- dehumidifier
- air purifier;
- beauty and barber services;
- recliner lift;
- travel expenses, whether or not prescribed by a *physician*;
- raised toilet seats;
- toilet seat systems;
- cribs;
- ramps;
- positioning wedges;
- wall or ceiling mounted lift systems;
- water circulating cold pads or cryo-cuffs;
- car seats including any vest system or car beds;
- bath or shower chair systems;
- trampolines;
- tricycles;
- therapy balls; and
- net swings with a positioning seat.

Repatriation and medical evacuation services for transportation back to the United States from another country. This exclusion does not apply to air and water ambulance services as described in Section 3, which provides for transportation to the nearest facility where the required services can be performed.

Research studies.

Self-treated services or services provided by relatives whether by blood, marriage, or adoption, or other members of your household.

Services related to sexual dysfunctions, except *medically necessary* services for treatment related to an organic condition.

Programs or drugs designed for the purpose of weight loss, including but not limited to, commercial diet plans, weight loss *programs*, and any services in connection with such plans or *programs*.

Health assessment *programs* designed to provide personalized treatment plans. These treatment plans can include but are not limited to:

- cardiovascular assessments;
- diet;
- exercise; and
- lifestyle guidance.

SECTION 5: REQUESTS FOR AUTHORIZATION, DENIAL S, COMPLAINTS, AND APPEALS

Requests for Authorization

We evaluate the *medical necessity* of select *covered healthcare services* using clinical criteria to facilitate clinically appropriate, cost-

Covered services provided by:	Preauthorization is the responsibility of the:
Network Providers	*Provider*
Non-Network Providers	*Member*
BlueCard Providers:	
Inpatient Services	
Other Services	

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*, you can request a *network authorization* to seek services from a *non-network provider*. With an approved *network authorization*, the *network benefit* level will apply to the authorized *covered healthcare service*. If we approve a *network authorization* for you to receive services from a *non-network provider*, our reimbursement will be based on the lesser of our *allowance*, the *non-network provider's charge*, or the *benefit limit.* For more information, please see the How *Non-Network Providers* Are Paid section.

Denials

A *claim* denial, also known as an adverse *benefit* determination, is any of the following:
- a full or partial denial of a *benefit*;
- a reduction of a *benefit*;
- a termination of a *benefit*;
- a failure to provide or make a full or partial payment for a *benefit*; and
- a rescission of coverage, even if there is no adverse effect on any *benefit*.

If we deny payment for a service we determine not *medically necessary*, a determination letter will be provided with the following information:
- reason for the denial;
- clinical

If the concern or issue is not resolved to *y*our satisfaction, you may file a verbal or written complaint with our Grievance and Appeals Unit.

within forty-five (45) calendar days of receiving of the reconsideration denial letter.

You will receive written notification of our appeal determination following the same timeframes noted in the How to File a Medical Request for Reconsideration section above.

At any time during the review process, you may supply additional information to us. You may also request copies of information relevant to your request (free of charge) by contacting our Grievance and Appeals Unit.

How to File an Appeal of a Prescription Drug Denial
For denials of a prescription drug *claim* based on our determination that the service was not *medically necessary* or appropriate, or that the service was *experimental or investigational*, you may request an appeal without first submitting a request for reconsideration.

You or your *physician* may file a written or verbal prescription drug appeal with our pharmacy *benefits* manager (PBM). The prescription drug appeal must be submitted to us within one hundred and eighty (180) calendar days of the initial determination letter. You will receive written notification of our determination within thirty (30) calendar days from the receipt of your appeal.

How to File an Expedited Appeal
Your appeal may require immediate action if a delay in treatment could seriously jeopardize your health or your ability to regain maximum function, or would cause you severe pain.

To request an expedited appeal of a denial related to services that have not yet been rendered (a *preauthorization* review) or for on-going services (a concurrent review), you or your healthcare *provider* should call:

our Grievance and Appeals Unit; or
our pharmacy *benefits* manager for a prescription drug appeal.

Please see Section 9 for contact information.

You will be notified of our decision no later than seventy-two (72) hours after our receipt of the request.

You may not request an expedited review of *covered healthcare services* already received.

How to Request an External Appeal
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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

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*agree not to bill,

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*

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.

- For the following circumstances the *non-network provider* cannot balance bill you, 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).

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

If you experience a problem relating to one of the special circumstances described above, please see Section 5 for information about how to submit an appeal.

How BlueCard Providers Are Paid: Coverage for Services Provided Outside Our Serviced Area

Overview

BCBSRI has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called “Inter-*Plan* Arrangements.” These Inter-*Plan* Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association (“

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of *inpatient*, *outpatient* and professional *providers*, the *network* is not served by a Host Blue. As such, when you receive care from *providers* outside the *BlueCard* service area, you will typically have to pay the *providers* and submit the *claims* yourself to obtain reimbursement for these services.

Inpatient Services: In most cases, if you contact the service center for assistance, *hospitals* will not require you to pay for covered *inpatient* services, except for *y*our cost-share amounts/*deductibles*, coinsurance, etc. In such cases, the *hospital* will submit *y*our *claims* to the service center to begin *claims* processing. However, if you paid in full at the time of service, you must submit a *claim* to receive reimbursement for *covered healthcare services*. *Preauthorization* may be required for non-*emergency inpatient* services.

2. *Plan* does not include: *hospital* indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited *benefit* health coverage, as defined by state law; school accident type coverage; university student health plans; *benefits* for non-medical components of long-term care policies; Medicare supplement policies;

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.

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:

the *benefits* of the *plan* covering the parent born earlier in the year will be determined before those of the parent whose birthday (month and day only) falls later in the year;

if both parents have the same birthday, the *benefits* of the *plan* that covered the parent longer are determined before those of the *plan* which covered the other parent for a shorter period of time;

if the other *plan* does not determine *benefits* according to the parents' birth dates, but by parents' gender instead, the other *plan*ôs gender rule will determine the order of *benefits*.

(3) Dependent Child/Parents Separated or Divorced

If two or more *plans* cover a person as a dependent child of divorced or separated parents, the *plan* responsible to cover *benefits* for the child will be determined in the following order:

first, the *plan* of the parent with custody of the child;

then, the *plan* of the spouse of the parent with custody of the child; and

finally, the *plan* of the parent not having custody of the child.

If the terms of a court decree state that:

one of the parents is responsible for the healthcare expenses of the child, and the entity obligated to pay or provide the parent's *benefits* under that parent's *plan* has actual knowledge of those terms, the *benefits* of that *plan* are determined first and the *benefits* of the *plan* of the other parent are the *secondary plan*.

both parents share joint custody, without stating that one of the parents is responsible for the healthcare expenses of the child, the *plans* covering the child will follow the order of *benefit* determination rules outlined above.

(4) Active/Inactive Employee
If you are covered under another *plan* as an active employee, *y*our *benefits* and those of *y*our dependents under that *plan* will be determined before *benefits* under this *plan*. The *plan* covering the active employee and dependents will be the *primary plan*. The *plan* covering that same employee as inactive (including those who are retired or have been laid off) will be the *secondary plan* for that employee and dependents.

(5) COBRA/Rhode Island Extended Benefits (RIEB)
If this *plan* is provided to you under COBRA or RIEB, and you are covered under another *plan* as an employee, retiree, or dependent of an employee or retiree, the *plan* covering you as an employee, retiree or dependent of an employee or retiree will be *primary* and the COBRA or RIEB *plan* will be the *secondary plan*.

(6) Longer/Shorter Length of Coverage
If none of the above rules determine the order of *benefits*, the *benefits* of the *plan* that covered a *member* or *subscriber* longer are determined before those of the *plan* that covered that person for the shorter term.

How We Calculate Benefits Under These Rules
When this *plan* is *secondary*, it may reduce its *benefits* so that the total *benefits* paid or provided by all *plans* are not more than the total *allowable expenses*. In determining the amount to be paid for any *claim*, the *secondary plan* will calculate the *benefits* it would have paid in the absence of other healthcare coverage and apply that calculated amount to any *allowable expense* under its *plan* that is unpaid by the *primary plan*. The *secondary plan* may then reduce its payment by the amount so that, when combined with the amount paid by the *primary plan*, the total *benefits* paid or provided by all *plans* for the *claim* do not exceed the total *allowable expense* for that *claim*. In addition, the *secondary plan* shall credit to its *plan deductible* any amounts it would have credited to its *deductible* in the absence of other healthcare coverage.

Our Right to Make Payments and Recover Overpayments

If payments which should have been made by us according to this provision have actually been made by another organization, we have the right to pay those organizations the amounts we decide are necessary to satisfy the rules of this provision. These amounts are considered *benefits* provided under this *plan* and we will not have to pay those amounts again.

If we make payments for *allowable expenses*, which are more than the maximum amount needed to satisfy the conditions of this provision, we have the right to recover the excess amounts from:

the person to or for whom the payments were made;
any other insurers; and/or
any other organizations (as we decide).

As the *subscriber*, you agree to pay back any excess amount paid, provide information and assistance, or do whatever is necessary to aid in the recovery of this excess

amount. The amount of payments made includes the reasonable cash value of any *benefits* provided in the form of services.

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

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

MAXIMUM OUT-OF-POCKET EXPENSE means the total amount you pay each *plan year* for *covered healthcare services*. We will pay up to 100% of our *allowance* for the *covered healthcare service* for the rest of the *plan year* once you have met the *maximum out-of-pocket expense*. See the Summary of Medical *Benefits* for *y*our *maximum out-of-pocket expenses*.

MEDICAL PRESCRIPTION DRUGS are prescription drugs that require administration (or the FDA approved recommendation is for administration) by a licensed healthcare *provider* (other than a pharmacist). 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. *Medical prescription drugs* are covered as a medical *benefit*.

***MEDICALLY NECESSARY* (*MEDICAL NECESSITY*)** means that the healthcare services provided to treat *y*our illness or injury, upon review by BCBSRI are:

appropriate and effective for the diagnosis, treatment, or care of the condition, disease, ailment or injury for which it is prescribed or performed;

appropriate with regard to generally accepted standards of medical practice within the medical community or scientific evidence;

not primarily for the convenience of the *member*, the *member*ôs family or *provider* of such *member*; and

NETWORK PROVIDER is a *provider* that has entered into a contract to participate in the Blue Choice New England. The Blue Choice New England service area consists of Rhode Island, Connecticut, Maine, Massachusetts, and New Hampshire.

NEW SERVICE means a service, treatment, procedure, facility, equipment, drug, device, or supply we previously have not reviewed to determine if the service is eligible for coverage under this *plan*.

NON-NETWORK PHARMACY is any pharmacy that has not entered into a contract to accept our *pharmacy allowance* for prescription drugs and diabetic equipment or supplies covered under this *plan*.

NON-NETWORK PROVIDER is a *provider* that has not entered into a contract to participate in the Blue Choice New England *network*.

OUTPATIENT means a person who is receiving care other than on an *inpatient* basis, such as:

in a *provider's* office;

in an

SOUND NATURAL TEETH means teeth that:
are free of active or chronic clinical decay;
have at least fifty percent (50%) bony support;
are functional in the arch; and
have not been excessively weakened by multiple dental procedures.

SPECIALTY PRESCRIPTION DRUG is a type of prescription drug listed on our *formulary* that generally is identified by, but not limited to, features such as:
being produced by DNA technology;
treats chronic or long-term disease;
requires customized clinical monitoring and patient support; and
needs special handling.

SUBSCRIBER is the person who enrolls in this *plan* and signs the application on behalf of himself or herself and on behalf of the other family members listed as eligible on the application.

SUBSTANCE USE DISORDER means the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) or the International Classification of Disease Manual (ICO) published by the World Health Organization.

URGENT CARE CENTER means a healthcare center which provides care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires *emergency* room care. An *urgent care center* can be affiliated with a *hospital* or other institution or independently owned and operated. These centers may also be referred to as walk-in centers.

UTILIZATION REVIEW means the prospective (prior to), concurrent (during) or retrospective (after) review of any service to determine whether such service was properly authorized, constitutes a *medically necessary* service for purposes of *benefit* payment, and is a *covered healthcare service* under this *plan*.

WE*, *US*,** and ***OUR means Blue Cross & Blue Shield of Rhode Island. WE, US, or OUR will have the same meaning whether *italicized* or not.

YOU and **YOUR** means the *subscriber* or *member* enrolled for coverage under this *agreement*. YOU and YOUR will have the same meaning whether *italicized* or not.

SECTION

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 (+) - Three (3) in-vitro cycles will be covered per *plan year* with a total of eight (8) in-vitro cycles covered in a *member's* lifetime.		
When purchased at a Specialty, Mail Order, or Retail Pharmacy	Tier 1: 20% Tier 2: 20%	Not Covered Not Covered

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 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 form (located on our website), contact our Customer Service Department, or have your prescribing *provider* submit a request for you. We will respond to you with a determination within seventy-two (72) hours following receipt of the request. For standard exception reviews, if the exception is approved, we will cover the prescription drug for the duration of the prescription, including refills.

How to Request an Expedited Prescription Drug Coverage Exception Review
You may request an expedited review if a delay could significantly increase the risk to your health or your ability to regain maximum function, or you are undergoing a current course of treatment with a drug not on our

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.

Administration Services
When a *medical prescription drug* is administered by infusion, the administration of the prescription drug may be covered separately from the prescription drug. See Infusion Therapy - Administration Services in the Summary of Medical *Benefits* for *benefit limits* and the amount you pay.

Prescription drugs that are self-administered are not covered as a medical *benefit* but may be covered as a pharmacy *benefit*. Please see Pharmacy Prescription Drugs and Diabetic Equipment or Supplies – Pharmacy Benefits section above for additional information.

Site of Care Program
For some *medical prescription drugs*, after the first administration, coverage may be limited to certain locations (for example, a designated *outpatient* or ambulatory service facility, *physician*ôs office, or your home), provided the location is appropriate based on your medical status. For a list of *medical prescription drugs* that are subject to this Site of Care Program, visit our website.

Preauthorization may be required to determine *medical necessity* as well as appropriate site of care. If we deny your request for *preauthorization*, or you disagree with our determination for the appropriate site of care, you can submit a medical appeal. See Appeals in Section 5 for information on how to file a medical appeal.

English:

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: