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

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Deductible/Maximum Out -of-Pocket Expense

Deductible; Maximum Out-of-Pocket Expense		
	You Pay	You Pay

Summary of Medical Benefits

Covered Benefits - See Covered Healthcare Services for additional benefit limits and details.	Network Providers	Non-network Providers

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

SECTION 1: INTRODUCTION TO YOUR SUBSCRIBER AGREEMENT

Thank you for choosing Blue Cross & Blue Shield of Rhode Island (BCBSRI) for *y*our healthcare coverage. We appreciate the trust you ¶ Y H S O D Ds F H G Q 1 Q to help you make the most of *y*our health *plan*.

In this *Subscriber Agreement* (*agreement*), you ¶ O O I L Q G Y D O X D E O H \ R X U L Q I R U P D W L *plan*, including:

- how *y*our health coverage works;
- how BCBSRI processes *claims* for the health services you receive;
- *y*our rights and responsibilities as a BCBSRI *member*;
- BCBSRI ¶ V U L J K W V D Q G U H V S R Q V L E L O L W L H V D Q G tools and programs to help you stay healthy and save money.

We encourage you to read this *agreement* to learn about all the advantages of being a BCBSRI *member*.

How to Use This Agreement

Below are some helpful tips on how to find what you need in this *agreement*.

- As a *member*, you are responsible for understanding the *benefits* to which you are entitled under this *agreement* and the rules you must follow to receive those *benefits*.
- The Table of Contents will help you find the order of the sections as they appear in the *agreement*.
- The Summary of *Benefits*, included in this *agreement*, shows the amount you pay out of *y*our own pocket.
- Important contact information, such as, telephone numbers, addresses, and websites are located at the end of this document.
- Some words and phrases used in this *agreement* are in *italics*. This means that the words or phrases have a special meaning as they relate to *y*our healthcare coverage. Please see Section 8 for definitions of these words.
- When we X V H W K H w Z H R U V G V D Q G ³ we are referring to BCBSRI. When we use the words ³you´ D Q G ³your³ we are referring to the enrolled *subscriber* and/or *member*. These words are also defined in the Glossary.
- Many sections of this document are related to other sections. You may need to reference more than one section to find the information you need.

Contact Us If You Have a Question

If you have questions about *y*our *benefits* or anything in this *agreement*, we are happy

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.
- Keep it in a safe location, just as you would with a credit card or money.
- Let BCBSRI know right away if it is lost or stolen.

Your Guide to Selecting a

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*

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 your H P S O R \ H U ¶ V 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:

Your legal spouse: according to the laws of the state in which you were married.

Your common law spouse: according to the law of the state in which your marriage was formed. To be eligible, you and your 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.

Your 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, your former spouse may continue to be eligible for coverage provided that your divorce decree requires it in accordance with state law. Your former spouse will remain eligible on your 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 your former spouse has comparable coverage available through his or her own employment.

Domestic Partner: your domestic partner may be eligible to enroll for coverage provided your employer authorizes the eligibility of domestic partners. You and your domestic partner may be required to complete a Declaration of Domestic Partnership form and provide the required documentation listed on the form. Please contact your employer to determine if your domestic partner is eligible and for any additional information regarding coverage for domestic partners.

Your Children

Natural children;
Step-children;
Legally adopted children;
Foster children who have been placed with you by an authorized placement agency or court order.
Children of your domestic partner, provided your employer authorizes the eligibility of domestic partners.

A child for whom healthcare coverage is required through a Qualified Medical Child Support Order or other court or administrative order is also eligible for coverage. *Y*our employer is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

We may request more information from you to confirm *y*our F K L O G ¶ V H O L J L E L O L W \

Disabled Dependents
In accordance with R.I. General Law § 27-20-45, when *y*our enrolled unmarried child reaches the maximum dependent age of twenty-six (26), he or she can continue to be considered an eligible dependent only if he or she is determined by us to be a disabled dependent.

If you have an unmarried child of any age who is financially dependent upon you and

Special Enrollment Period

A Special Enrollment Period is a time outside the yearly Open Enrollment Period when you can sign up for health coverage. You and your eligible dependents may enroll for coverage through a Special Enrollment Period by providing required enrollment information within thirty (30) days of the following events:

you get married, the coverage effective is the first day of the month following your marriage.

you have a child born to the family, the coverage effective date is the date of birth.

you have a child placed for adoption with your family, the coverage effective date is the date of placement.

Special Enrollment If You Are Pregnant

In accordance with RIGL §27-18.6-3.1, if you are a pregnant individual, you are eligible to enroll for coverage at any time after the commencement of your pregnancy. Coverage will be effective the first of the month in which we receive your application for enrollment.

Special note about enrolling your newborn child: You must notify your employer of the birth of a newborn child and pay the required premium within thirty-one (31) days of the date of birth. Otherwise, the newborn will not be covered beyond the thirty-one (31) day period. This *plan* does not cover services for a newborn child who remains hospitalized after thirty-one (31) days and has not been enrolled in this *plan*.

If you are enrolled in an Individual *Plan* when your child is born, the coverage for thirty-one (31) days described above means your *plan* becomes a Family *Plan* for as long as your child is covered. Applicable Family *Plan deductibles* and *maximum out-of-pocket expenses* may apply.

In addition, if you lose coverage from another *plan*, you may enroll or add your eligible dependents for coverage through a Special Enrollment Period by providing required enrollment information within thirty (30) days following the date you lost coverage. Coverage will begin on the first day of the month following the date your coverage under the other *plan* ended. In order to be eligible, the loss of coverage must be the result of:

legal separation or divorce;

death of the covered policy holder;

termination of employment or reduction in the number of hours of employment;

the covered policy holder becomes entitled to Medicare;

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

SECTION 3: COVERED HEALTHCARE SERVICES

For all ***covered healthcare services***, please see the Summary of Medical ***Benefits*** and the Summary of Pharmacy ***Benefits*** to determine the amount that you pay and any ***benefit limits***.

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

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.

Intermediate care services include the following:

- Partial Hospital Program (PHP) ±PHPs are s

Medication Assisted Treatment
This *plan* covers medication assisted treatment for *substance* use *disorders*, including methadone maintenance treatment. Please see the Summary of Medical *Benefits* for specific *copayments* for these services.

Cardiac Rehabilitation

This *plan* covers services provided in a cardiac rehabilitation *program* up to the *benefit limit* shown in the Summary of Medical *Benefits*.

Chiropractic Services

This *plan* covers chiropractic visits up to the *benefit limit* shown in the Summary of Medical *Benefits*. The *benefit limit* applies to any visit for the purposes of chiropractic treatment or diagnosis.

Dental Services

Services to Treat an Accidental Injury

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

blood glucose monitors including those with special features for the legally blind, external insulin infusion pumps and accessories, insulin infusion devices and injection

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.

The amount that you

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

drugs;
intensive care/coronary care;
nursing care;
physical, occupational, speech and respiratory therapies;
*physician*ûs 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*.

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 disse0912 03s12 0 3ry of

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 that are integral to the harvesting or directly related to the donation and limited to treatment occurring during the same stay as the harvesting and treatment received during standard post-operative care; and
- transportation of the organ from donor to the recipient.

The amount you pay for transplant services, for the recipient and eligible donor, is based on the type of service.

Pediatric Neuropsychiatric Disorder Services

In accordance with RIGL § 27-20-60, this *plan* covers services for the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute onset neuropsychiatric syndrome (PANS). Treatment includes but is not limited to the use of intravenous immunoglobin therapy.

Preauthorization may be required for certain services to treat PANDAS or PANS. The amount you pay depends on the *covered healthcare service* you receive, as indicated in the Summary of Medical *Benefits* and the Summary of Pharmacy *Benefits*.

Physical/Occupational Therapy

This *plan* covers physical and occupational therapy when:

- ordered by a *physician*;
- received from a licensed physical or occupational therapist;
- a *program* is implemented to provide *habilitative* or *rehabilitative* services.

See Autism Services when physical therapy and occupational therapy services are rendered as part of the treatment of autism spectrum disorder.

The amount you pay and any *benefit limit* will be the same whether the services are provided for *habilitative* or *rehabilitative* purposes.

Pregnancy and Maternity Services

The €O À This *plan* covers *physician* services and the services of a licensed midwife for prenatal, delivery, and postpartum care. The first office visit to diagnose

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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
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*

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Private Duty Nursing Services

Preauthorization may be required for certain surgical services.

Reconstructive Surgery for a Functional Deformity or Impairment
This *plan* covers reconstructive surgery and procedures when the services are performed to relieve pain, or to correct or improve bodily function that is impaired as a result of:

a

When you receive a *covered healthcare service* from a *network* or *non-network provider*

SECTION 4: EXCLUSIONS

This section lists the services or categories of services that are not covered (excluded) under this *plan*

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, including medical marijuana, which are dispensed in violation of state and/or federal law.

Private Duty Nursing Services

Services of a nurse's aide.
Services of a private duty nurse:

- when the primary duties are limited to bathing, feeding, exercising, homemaking, giving oral medications or acting as companion or sitter;
- after the caregiver or patient have demonstrated the ability to carry out the plan of care;
- provided outside the home. Examples include at school, or in a nursing or assisted living facility;
- that are duplication or overlap of services. Examples include when a person is receiving hospice care services or for the same hours of a skilled nursing home care visit;
- that are for observation only; and
- provided as part-time/intermittent and not continuous care.

Maintenance care when the condition has stabilized including routine ostomy care or tube feeding administration or if the anticipated need is indefinite.
Twenty-four (24) hour private duty nursing care for a person without an available caregiver in the home.
Respite care (e.g., care during a caregiver vacation) or private duty nursing so that the caregiver may attend work or school.

Surgery Services

Abdominoplasty.
Brow ptosis surgery.
Cervicoplasty.
Chemical exfoliations, peels, abrasions, dermabrasions, or planing for acne, scarring, wrinkling, sun damage or other benign conditions.
Correction of variations in normal anatomy including augmentation mammoplasty, mastopexy, and correction of congenital breast asymmetry.
Dermabrasion.
Ear piercing or repair of a torn earlobe.

Covered healthcare services provided to you when there is no *charge* to you or there would have been no *charges* to you absent this health *plan*.

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:

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

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;

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*

Covered s ervices provided by:	Preauthorization is the responsibility of the:
Network Providers	*Provider*
Non-Network Providers	*Member*
BlueCard Providers: *Inpatient*	

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

You are not required to file a complaint (as described above), before filing an administrative appeal. If you call our Customer Service Department, a Customer Service Representative will try to resolve your concern. If the issue is not resolved to your satisfaction, you may file a verbal or written administrative appeal with our Grievance and Appeals Unit.

If you request an administrative appeal, you must do so within one hundred eighty (180) days of receiving a denial of payment for *covered healthcare services*.

The Grievance and Appeals Unit will conduct a thorough review of your administrative appeal and respond within:

- thirty (30) calendar days for a prospective review; and
- sixty (60) calendar days for a retrospective review.

The letter will provide you with information regarding our determination.

Medical Reconsiderations and Appeals

A medical reconsideration or appeal is a request for us to reconsider a full or partial denial of payment for *covered healthcare services* because we determined:

- the service was not *medically necessary* or appropriate. England Lang (en-US)>> BDC q 0.00000912 0

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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.

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 recequ that the service was

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 employe12 792 re W* n external review prior to filing a s

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*ôs 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

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:

Value-

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

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 entit 0.00000912 0 612 792 re W* n BT /F8 12 Tf 1 0 0 1 147.38 248.18 Tm 29l2 0 in0 1 147.38

(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*

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

CHARGES means the amount billed by any healthcare *provider* (e.g., *hospital*

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

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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 *ambulatory surgical center* or facility;
in an *emergency* room; or
in a clinic.

PHARMACY ALLOWANCE means the lower of:

the amount the pharmacy *charges* for the prescription drug; or
the amount we or our PBM have negotiated with a *network pharmacy*

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PHYSICIAN means any person licensed and registered as an allopathic or osteopathic physician (i.e., D.O or M.D.). For purposes of this *plan*, the term *physician* also includes a licensed *dentist*, podiatrist, chiropractic physician, nurse practitioner, or a physician assistant.

PLAN means any health insurance *benefit* package provided by an organization.

PRIMARY CARE PROVIDER (***PCP***) means, for the purpose of this *plan*, professional *providers* that are family practitioners, internists, and pediatricians. For the purpose of this *plan*, gynecologists, obstetricians, nurse practitioners, and physician assistants may be credentialed as *PCPs.* To find a *PCP* or check that your *provider* is a *PCP*, please XVH WKH ³)LQG D 'RFWRU´ WRRO RQ RXU ZHEVLWH RU FDOO

PROGRAM means a collection of *covered healthcare services*, billed by one *provider*, which can be carried out in many settings and by different *providers*. This *plan* does not cover *programs* unless specifically listed as covered.

PROVIDER means an individual or entity licensed under the laws of the State of Rhode Island or another state to furnish healthcare services. For purposes of this *plan*, the term *provider* includes a *physician* and a *hospital*. It also means individuals whose services we must cover under Title 27, Chapters 19 and 20 of the R.I. General Laws, as amended from time to time.

A *provider* includes:

- midwives;
- certified registered nurse practitioners;
- psychiatric and behavioral health nurse clinical specialists practicing in collaboration with or in the employ of a *physician*;
- counselors in behavioral health; and
- therapists in marriage and family practice.

Healthcare services are only covered if those services are provided within the scope of the *providerÕs* license.

REFERRAL means the approval that *members* must obtain from their *PCP* prior to seeking *covered healthcare services* from other *network providers*.

REHABILITATIVE SERVICES (***REHABILITATIVE***) means healthcare services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired due to being sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of *inpatient* and/or *outpatient* settings. These acute short-term therapies can only be provided by a qualified professional.

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 (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.

Our release of information about you is regula law. Please see de Island Confidentiality of HealthCare Communication formation Act, . Laws §§ 5-37.3-1 et seq. the Health Insurance Portability ccountability A 96, as amended by the Health Information Technology for Eco and Clinical H , and L P S O H P H Q W L Q J U H J X O D W L &) 5 H W -V H T Leach-Bliley Financial Modernization Act, 15 §§ 6801-6908 ode Island Office of the Health Insurance Commissioner (OHIC ation 100.

Statement of Rights Under the Newb and Mothe lth Protection Act

Under federal law, group health *plans* and he urance issuers group healthcare coverage generally may not restri *its* for any *hospit* of stay in connection with childbirth for the mother or ne child to less than 48) hours following a vaginal delivery, or less than nine 6) hours following a cesarean section. However, the *plan* or issue ay for a shorter stay if the *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

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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 (+) - *plan year*		

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
Diabetes, Asthma, and COPD Prescription Drugs		
copayment *copayments*		
Prescription Drugs Administered by a Provider (other than a Pharmacy).	*Benefits*	*Benefits*

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*.

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 ***formulary***. Please indicate ³ X U J H Q W Coverage Exception form or inform Customer Service of the urgent nature of your request. We will respond to you with a determination within twenty-four (24) hours following receipt of the request. For expedited exception reviews, if the exception is approved, we will cover the prescription drug for the duration of the exigency.

For both standard and expedited exception reviews, if we grant your request for a prescription drug coverage exception, the amount you pay will be the *copayment* at the highest pharmacy prescription drug tier in your ***plan*** as shown in the Summary of Pharmacy *Benefits*. For *Medical Prescription Drugs* the amount you pay will be the prescription drugs *copayment* shown in the Summary of Medical *Benefits*. Other applicable *benefit* requirements, such as step therapy, are not waived by this exception and must be reviewed separately.ception, complete a

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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.

The Amount You Pay for Prescription Drugs
Our *formulary* includes a tiered *copayment* structure, which means the amount you pay for prescription drugs purchased at a pharmacy will vary by tier. See the Summary of Pharmacy *Benefits* for your

B. Medical Benefits - Prescription Drugs Administered by a Provider (other than a pharmacist)

This *plan* covers prescription drugs as a medical *benefit* U H I H U U H *medical* R D V 3 *prescription drugs*ò when the prescription drug requires administration (or the FDA approved recommendation is administration) by a licensed healthcare *provider* (other than a pharmacist). Please note: Certain prescription drugs meeting these requirements or recommendations may be designated as a specialty prescription drug and will be covered as a pharmacy *benefit* and not a medical *benefit*. When this occurs, these specialty *prescription drugs* will be listed on our *formulary*.

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

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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: