Subscriber Agreement

HealthMate for HSA Direct

Plan 3000/6000

You have the right to return this agreement within ten (10) days after receipt if you are not satisfied with it for any reason. We will refund your membership fee if this agreement is returned to us within ten (10) days.

RENEWABILITY PROVISIONS

This agreement will automatically renew on the *plans* renewal date, which is April 1st of each *calendar year*, providing your membership fees are paid, except if one of the events applies from Section 2.2 entitled "When Your Coverage Ends". (See Section 2 for details.)

Blue Cross Blue Shield of Rhode Island

Your Plan for Life™

Pursuant to Section 223 of the Internal Revenue Code (IRC), this *plan* qualifies as a *High Deductible Health Plan* (*HDHP*) which is suitable for use with a *Health Savings Account* (*HSA*). Any conflict between the terms of this policy and the provisions of Section 223 of the IRC will be resolved in favor of Section 223 of the IRC in order to preserve any potential tax benefits to the *subscriber*. This *plan* may be used in conjunction with a *HSA*, but it is not an *HSA* itself.

BLUE CROSS & BLUE SHIELD of RHODE ISLAND
HEALTHMATE for HSA DIRECT
Plan 3000/6000
SUBSCRIBER AGREEMENT

This is a legal agreement between you and Blue Cross & Blue Shield of Rhode Island. Your identification (ID) card will identify you as a *member* when you receive the health care services covered under this agreement. By presenting your ID card to receive *covered health care services,* you are agreeing to abide by the rules and obligations of this agreement.

You hereby expressly acknowledge your understanding that this contract is solely between you and Blue Cross & Blue Shield of Rhode Island. Blue Cross & Blue Shield of Rhode Island is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("the Association"), an association of independent Blue Cross and Blue Shield *plans*, permitting us to use the Blue Cross and Blue Shield Service Marks. We are not contracting as the agent of the Association. You further acknowledge and agree that you have not entered into this contract based upon representations by anyone other than us and that no person, entity or organization other than us shall be held accountable or liable to you for any of our obligations to you under this contract. This paragraph shall not create any additional obligations on our part other than those obligations created under other provisions of this agreement.

James E. Purcell
President and Chief Executive Officer

Frank J. Montanaro
Chairman

THIS CONTRACT IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us.

SUMMARY OF BENEFITS

This is a summary of our coverage levels under this agreement. It includes information about *copayments*, *deductibles,* and some benefit limits. This summary is intended to give you a general understanding of the coverage available under this agreement. **For more detailed information, please read Section 3.0 for the description of coverage for each particular *covered health care service* along with the related exclusions, and Section 5.0 for a list of general exclusions.**

IMPORTANT NOTE: All of our payments at the benefit levels noted below are based upon a fee schedule called our *allowance*. If you receive services from a *network provider*, the *provider* has agreed to accept our *allowance* as payment in full for *covered health care services*, excluding your *copayments*, *deductible,* and the difference between the *maximum benefit* and our *allowance,* if any. If you receive *covered health care services* from a *non-network provider*, you will be responsible for the *provider's charge*. You will then be reimbursed based on the lesser of the *provider's charge,* our *allowance,* or the *maximum benefit;* less any *copayments* and/or *deductibles.* The *deductible, maximum out-of-pocket expense,* and *plan lifetime maximums* are calculated based on the lower of our *allowance* or the *provider's charge,* unless otherwise specifically stated in this agreement.

DEPENDENT AGE LIMITS	
Dependent Age	**See Section 2.1 – Who is Eligible for Coverage.**
Dependent Children	Unmarried dependent children are covered until January 1st following their 19th birthday.
Dependent Students	Unmarried dependent children are covered until January 1st following their 25th birthday when enrolled as a student and financially dependent upon you. If student status ends, coverage will end the first day of the month following the end of student status.

SUMMARY OF MEDICAL BENEFITS			
Deductible/ Maximum Out-of-Pocket Expense/Plan Lifetime Maximum	**Type of Contract**	***Network Provider***	***Non-Network Provider***
Deductible* per *calendar year The *deductible* applies to all covered expenses, with the exception of certain *preventive care services.* The *deductible* applies to *network provider* and *non-network provider* services separately.	Single	$3000 per individual per *calendar year*.	$3000 per individual per *calendar year*.
	Family The family *deductible* is met by collectively adding the amount of covered health care expenses applied to the *deductible* for all eligible family *members*.	$6000 per family aggregate per *calendar year*.	$6000 per family aggregate per *calendar year*.
Maximum Out-of-Pocket Expense* per *calendar year The *deductible and copayments apply* to the *maximum out-of-pocket expense*.	Single		$6000 per individual per *calendar year*.
	Family The family *maximum out-of-pocket expense* is met by collectively adding the amount of covered health care expenses applied to the *deductible* and *copayment* for all eligible family *members*.		$12000 per family aggregate per *calendar year*.
Plan Lifetime Maximum	Per *Member*	Unlimited	Unlimited

Continued	Summary of Medical Benefits		See Important Note from First Page	
Type of Service	Section	Benefit Limit	Level of Coverage *Network Provider*	*Non-Network Provider*
Ambulance	3.1			
• Ground	3.1		After *deductible* 100% coverage.	After *deductible* 60% coverage.
• Air/water	3.1	Up to the *maximum benefit* of $3000 per occurrence.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
Behavioral Health	3.2			
Mental Health Services	3.2			
• *Inpatient* **(*)**	3.2	Unlimited days at *a general hospital* or *a specialty hospital.*	After *deductible* 100% coverage.	After *deductible* 60% coverage.
• *Outpatient,* In a *Provider's* office, or in your home	3.2	30 visits per *member* per *calendar year*.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
• Intermediate Care Services **(*)**	3.2	See Section 3.2 for details and limitations applicable to partial *hospital program*, intensive *outpatient program*, adult intensive services, and child and family intensive treatment.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
Chemical Dependency Treatment	3.2			
• *Inpatient* **(*)**	3.2	Detoxification: 5 admissions or 30 days per *calendar year*, which ever comes first. Intensive Rehabilitation/ Residential Treatment: 30 days per *calendar year*.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
• *Outpatient,* In a *Chemical Dependency Treatment Facility*, In a *Provider's* office, or in your home	3.2	30 hours per *member* per *calendar year*.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
• Intermediate Care Services **(*)**	3.2	See Section 3.2 for details and limitations applicable to partial *hospital program*, and intensive *outpatient programs.*	After *deductible* 100% coverage.	After *deductible* 60% coverage.
Cardiac Rehabilitation	3.3			
• *Inpatient*	3.3		After *deductible* 100% coverage.	After *deductible* 60% coverage.
• *Outpatient*	3.3	Benefit is limited to 3 visits per week for up to 12 weeks per covered condition. See Section 3.3 for details.	After *deductible* 100% coverage.	After *deductible* 60% coverage.

Continued	Summary of Medical Benefits		See Important Note from First Page	
Type of Service	Section	Benefit Limit	Level of Coverage *Network Provider*	*Non-Network Provider*
Chemotherapy Services *Inpatient, Outpatient,* or in a *doctor's o*ffice	3.31	Prescription drug coverage benefit level is based on service type and site of service. See Section 3.29 - Prescription Drugs for details.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
Chiropractic Medicine	3.4	12 visits per *member* per *calendar year*.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
Consultations in the *Hospital*	3.5	Must be requested by *doctor* in charge of your care.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
Contraceptive Prescription drugs and Devices	3.6		After *deductible* 100% coverage.	After *deductible* 60% coverage.
Diabetic equipment/ supplies provided by a licensed medical supply *provider* (other than a pharmacy).	3.7	See Section 3.7 for limitations.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
Diagnostic Imaging, Lab, and Machine Tests *Inpatient, Outpatient* or *Outpatient* Non-Hospital facility	3.8	See Section 3.8 for limitations.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
***Doctor's Hospital* Visits**	3.9		After *deductible* 100% coverage.	After *deductible* 60% coverage.
Early Intervention Services (EIS)	3.10	Up to the *maximum benefit* of $5000 per child, from birth to 36 months, per *calendar year*. The *provider* must be certified as an EIS *provider* by the Rhode Island Department of Human Services.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
Emergency Room Services	3.11	See Section 8.0 definition of *Emergency*.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
***Experimental/ Investigational* Services (*)**	3.12	Coverage varies based on type of service. See Section 3.12.		
Hemodialysis Services *Inpatient, Outpatient,* or in your home	3.13		After *deductible* 100% coverage.	After *deductible* 60% coverage.
Hemophilia Services *Outpatient* or in a *Doctor's* office	3.14		After *deductible* 100% coverage.	After *deductible* 60% coverage.

Continued	Summary of Medical Benefits		See Important Note from First Page	
			Level of Coverage	
Type of Service	Section	Benefit Limit	*Network Provider*	*Non-Network Provider*
Home Health Care	3.15	Intermittent skilled services when provided and billed by a home health care *provider*. For information regarding prescription drug coverage See Section 3.29.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
Hospice Care	3.16	When provided by a hospice care *program*. For information regarding prescription drug coverage See Section 3.29.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
Hospital Services • *Inpatient* **(*)**	3.17	Unlimited days at *a general hospital* or *a specialty hospital,* maximum of 45 days per *calendar year* for physical rehabilitation.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
House Calls	3.18		After *deductible* 100% coverage.	After *deductible* 60% coverage.
Human Leukocyte Antigen Testing	3.19	See Section 3.19 for limitations.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
Infertility Services	3.20	Prescription drug coverage benefit level is based on service type and site of service. See Section 3.29 - Prescription Drugs for details. Prescription drugs purchased at a *non-network pharmacy* are not covered.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
Infusion Therapy	3.21			
• *Inpatient*	3.21		After *deductible* 100% coverage.	After *deductible* 60% coverage.
• *Outpatient,* in the *Doctor's* office, or in your home	3.21	Prescription drug coverage benefit level is based on service type and site of service. See Section 3.29 - Prescription Drugs for details.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
Lyme Disease Diagnosis and Treatment	3.22		After *deductible* 100% coverage.	After *deductible* 60% coverage.
Medical Equipment(*), Medical Supplies, and Prosthetic Devices(*)	3.23			
• *Inpatient*	3.23		After *deductible* 100% coverage.	After *deductible* 60% coverage.
• *Outpatient*	3.23		After *deductible* 100% coverage.	After *deductible* 60% coverage.

Continued	Summary of Medical Benefits		See Important Note from First Page	
Type of Service	Section	Benefit Limit	Level of Coverage *Network Provider*	 *Non-Network Provider*
• Hearing Aid Services	3.23	For an *eligible person* under the age of 19; coverage is limited to the *maximum benefit* of $1500 per ear, per 3-year period per *member*.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
		For an *eligible person* age 19 and over; coverage is limited to the *maximum benefit* of $700 per ear, per 3-year period per *member*.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
• Hair Prosthesis (Wigs)	3.23	Benefit is limited to the *maximum benefit* of $350 per *member* per *calendar year* when worn for hair loss suffered as a result of cancer treatment.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
Office Visits	3.24			
• Asthma Education	3.24	Must be provided by a certified asthma educator. See Section 3.24 for detailed information.	After *deductible* 100% coverage.	60% coverage.
• Diabetes Education	3.24	Individual and group sessions are covered based on medical necessity.	After *deductible* 100% coverage.	60% coverage.
• *Hospital* Based Clinic Visits	3.24		After *deductible* 100% coverage.	60% coverage.
• Nutritional Counseling	3.24	Up to 6 visits per *calendar year* when prescribed by physician for treatment of illness.	After *deductible* 100% coverage.	60% coverage.
• Office Visits (other than Pediatric Office Visits)	3.24	**Preventive Visit** One routine adult physical examination and one routine gynecological examination per *calendar year* per *member.*	100% coverage *Deductible* does not apply.	60% coverage *Deductible* does not apply.
		Sick Visit	After *deductible* 100% coverage.	60% coverage.
• Pediatric Office Visits	3.24	**Well-Child Office Visits** Birth – 15 months: 8 visits 16 – 35 months: 3 visits 36 months – 19 years: 1 visit per *calendar year*.	100% coverage *Deductible* does not apply.	60% coverage *Deductible* does not apply.
		Sick Visit	After *deductible* 100% coverage.	After *deductible* 60% coverage.
• Specialist Visits	3.24	Routine and non-routine visits.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
• Urgent Care Centers	3.24	See Section 7.0 – definition of *urgent care center.*	After *deductible* 100% coverage.	After *deductible* 60% coverage.
Organ Transplants (*)	3.25	See Section 3.25 for detailed information.	After *deductible* 100% coverage.	After *deductible* 60% coverage.

Continued	Summary of Medical Benefits		See Important Note from First Page	
Type of Service	Section	Benefit Limit	Level of Coverage *Network Provider*	*Non-Network Provider*
Physical/ Occupational Therapy *Inpatient, Outpatient,* or in a *doctor's/* therapist's office	3.26		After *deductible* 100% coverage.	After *deductible* 60% coverage.
Podiatrist Services	3.27	See Section 3.27 for routine foot care exclusions.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
Pregnancy Services and Nursery Care	3.28	Includes pre-natal, delivery, and postpartum services.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
Prescription drugs dispensed and administered by a licensed health care *provider* (other than a pharmacist)	3.29	See Section 3.29 - Prescription Drugs for details.		
• Medications other than injected drugs, infused drugs, or Anti-neoplastic (chemotherapy) drugs used for Cancer Treatment	3.29	Medications are included in the *allowance* for the medical service being rendered. Includes chemotherapy prescription drugs used for other than cancer treatment.		
• Injectable drugs	3.29	Includes chemotherapy drugs used for other than cancer treatment.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
• Infused drugs	3.29	Includes chemotherapy drugs used for other than cancer treatment.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
• Anti-neoplastic (chemotherapy) drugs used for Cancer Treatment	3.29	Limited to oral, injectable, and infused anti-neoplastic drugs used for cancer treatment.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
Prescription Drugs Purchased at a Retail or Mail Order Pharmacy	3.29	See Summary of Pharmacy Benefits for benefit limits and level of coverage.		
Prevention and Early Detection Services	3.30			
• **Cancer Screenings**	3.30	This level of coverage applies to covered prevention and early detection services, except for the cancer screenings mentioned below. See Section 3.30 for details.	After *deductible* 100% coverage.	After *deductible* 60% coverage.

Continued	Summary of Medical Benefits		See Important Note from First Page	
Type of Service	Section	Benefit Limit	Level of Coverage *Network Provider*	*Non-Network Provider*
		Coverage is limited to Mammogram, Pap smear, and PSA test when performed for routine cancer screening. See Section 3.30 for limitations.	100% coverage *Deductible* does not apply.	60% coverage *Deductible* does not apply.
• **Immunizations**	3.30			
• Adult Immunizations	3.30	See Section 3.30 for limitations.	100% coverage *Deductible* does not apply.	60% coverage *Deductible* does not apply.
• Pediatric Immunizations	3.30	Coverage for pediatric immunizations includes the administration of the injection but not the biological agent. See section 3.30 for details.	100% coverage *Deductible* does not apply	After *deductible* 60% coverage.
• Travel Immunizations	3.30	As recommended by the Centers for Disease Control and Prevention.	100% coverage *Deductible* does not apply	After *deductible* 60% coverage.
Radiation Therapy	3.31			
• *Inpatient* or *Outpatient*	3.31		After *deductible* 100% coverage.	After *deductible* 60% coverage.
Respiratory Therapy	3.32	See *program* requirements in Section 3.32.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
Skilled Care in a Nursing Facility (*)	3.33		After *deductible* 100% coverage.	After *deductible* 60% coverage.
Smoking Cessation Programs	3.34			
• Counseling	3.34	Coverage is limited to 8 visits per *member* per *calendar year*.	After *deductible* 100% coverage.	After *deductible* 60% coverage.
• Nicotine replacement therapy	3.34	See the Summary of Pharmacy Benefits (below) for benefit limits and level of coverage.		
Speech Therapy (*) *Inpatient, Outpatient,* or in a *doctor's*/ therapist's office	3.35		After *deductible* 100% coverage.	After *deductible* 60% coverage.
Surgery Services *Inpatient, Outpatient*, or in a *doctor's* office	3.36		After *deductible* 100% coverage.	After *deductible* 60% coverage.
Vision Care Services	3.37	One routine eye exam per *calendar year*.	After *deductible* 100% coverage.	After *deductible* 60% coverage.

(*) *Preauthorization* is recommended for this service. If you do not obtain *preauthorization* and the services are determined to be not *medically necessary* or the setting where services were received is determined to be inappropriate, we will not cover these services. *Network providers* are responsible for obtaining *preauthorization* for all applicable *covered health care services*. When the *provider* is *non-network*, you are responsible for obtaining *preauthorization*. If you receive services from a *provider* that participates with an out of state Blue Cross or Blue Shield *plan*, you are responsible for obtaining *preauthorization*. See Section 7.0 - definition of *preauthorization* for details.

SUMMARY OF PHARMACY BENEFITS Prescription Drugs Purchased at a Retail or Mail Order Pharmacy				
See Important Note from First Page			**Level of Coverage**	
Type of Service	Section	Benefit Limit	*Network Pharmacy*	*Non-Network Pharmacy*
Prescription Drugs purchased at a Retail Pharmacy	3.29	*Copayment applies* per each 30-day supply or portion thereof of maintenance and non-maintenance prescription drugs. Nicotine replacement therapy is limited to the day supply listed above for up to fourteen (14) consecutive weeks per *calendar year.*	After *deductible* 100% coverage. Your *deductible* is based on the lower of our *allowance* or the retail cost of the prescription drug.	Not Covered
Prescription Drugs purchased at a Mail Order Pharmacy	3.29	Up to a 90-day supply of maintenance and non-maintenance prescription drugs. Nicotine replacement therapy is not covered when purchased at a mail order pharmacy.	After *deductible* 100% coverage. Your *deductible* is based on the lower of our *allowance* or the retail cost of the prescription drug.	Not Covered
Diabetic equipment and supplies	3.29			
• Purchased at a Retail Pharmacy	3.29	Glucometers, Test Strips, Lancet and Lancet Devices, and Miscellaneous Supplies (including alcohol swabs and calibration fluid).	After *deductible* 100% coverage. Your *deductible* is based on the lower of our *allowance* or the retail cost of the prescription drug.	Not Covered
• Purchased at a Mail Order Pharmacy	3.29		After *deductible* 100% coverage. Your *deductible* is based on the lower of our *allowance* or the retail cost of the prescription drug.	Not Covered
Anti-neoplastic (Chemotherapy) Prescription drugs used for Cancer Treatment when purchased at a pharmacy	3.29	Oral, injectable, or infused prescription drugs are covered.	After *deductible* 100% coverage. Your *deductible* is based on the lower of our *allowance* or the retail cost of the prescription drug.	Not Covered

Continued	**Summary of Medical Benefits**		**See Important Note from First Page**	
			Level of Coverage	
Type of Service	Section	Benefit Limit	*Network Provider*	*Non-Network Provider*
Prescription drugs dispensed and administered by a licensed health care *provider* (other than a pharmacist).	3.29	See Summary of Medical Benefits, above.		

Blue Cross & Blue Shield of Rhode Island
HEALTHMATE for HSA DIRECT
SUBSCRIBER AGREEMENT
HM HSA DIRECT 3000/6000 (04/07)

TABLE OF CONTENTS

1.0 INTRODUCTION

1.1 How to Find What You Need to Know

The Summary of Benefits at the front of this agreement will show you what health care services are covered under this agreement along with any benefit limits, *copayments* and/or *deductibles* you are responsible to pay as well as services for which *preauthorization* is recommended. The Table of Contents will help you find more details about these *covered health care services* as well as other important information about eligibility, how we pay for your *covered health care services*, *health care services* which are not covered under this agreement, how to file a *claim,* and how to appeal a *claim* when you or your health care *provider* does not agree with a benefit decision we have made.

1.2 You and Blue Cross & Blue Shield of Rhode Island

We, Blue Cross & Blue Shield of Rhode Island, agree to provide coverage for *medically necessary covered health care services* listed in this agreement. We only cover a service listed in this agreement if we determine that it is *medically necessary*. The term *medically necessary* is defined in Section 7.0 - Glossary. It does not include all medically appropriate services.

This agreement provides coverage for health care services that we have reviewed and determined are eligible for coverage. Health care services which we have not reviewed or which we have reviewed and determined are not eligible for coverage under this agreement are not covered under this agreement. If a service or category of service is not listed as covered, it is not covered under this agreement. Section 3.0 lists the health care services covered under this agreement along with their related exclusions and Section 5.0 lists general exclusions.

When possible, we review *new services* within six (6) months of the occurrence of one of those events described below to determine whether the *new service* is eligible for coverage under this agreement:

(a) the assignment of an American Medical Association (AMA) Current Procedural Terminology (CPT) code in the annual CPT publication;
(b) final FDA approval;
(c) the assignment of processing codes other than CPT codes or approval by governing/regulatory bodies other than the FDA; and
(d) submission to us of a *claim* meeting the criteria of (a), (b) or (c) above.

A health care service remains non-covered (excluded) if any of the following occur:

- a service is not assigned a CPT or other code;
- a service is not approved by the FDA or other governing body;
- we do not review a service within six (6) months of the effective date of the service; OR
- we make a determination, after review, not to cover the service under this agreement.

Entitlements for payment shall not be more than our *allowance*, as defined in Section 7.0. Any *deductibles*, *copayments*, and *charges* over our *allowance* must be paid by you. The coverage provided, after the application of any *deductible,* is a credit toward *charges* equal to our *allowance* less your required *copayment*, if any. All our payments are subject to the terms and conditions outlined in this agreement.

1.3 Agreement and Its Interpretation

Our entire contract with you consists of this agreement and your application which is made a part of this agreement. In the absence of fraud, all your statements in the application are representations and not warranties. We have the right and discretionary authority to determine eligibility for benefits and to construe the provisions of this agreement, and any such construction made by us in good faith, or any determination made by us in good faith with respect to coverage matters is binding upon you to the extent that it does not reduce your right to appeal or to take legal action as set forth in Section 6.0.

If this agreement changes, we will issue an amendment or new agreement signed by an officer of Blue Cross & Blue Shield of Rhode Island. We will mail or deliver written notice of any change to you.

This agreement shall be construed under and shall be governed by the applicable laws and regulations of the State of Rhode Island as amended from time to time.

You have the right to return this agreement within ten (10) days after receipt if you are not satisfied with it for any reason. We will refund your membership fee if this agreement is returned to us within ten (10) days.

1.4 Words With Special Meaning

Some words and phrases used in this agreement are in italics. This means that the words/phrases have a special meaning as they relate to your health care coverage. The glossary at the end of this agreement defines many of these words. Other sections of this agreement which also contain definitions of certain words and phrases are Section 3.0 which describes *Covered Health Care Services* and their related exclusions and Section 6.0 which addresses your right to appeal a decision that we make.

1.5 General Information

When you select a health care *provider*, you should refer to the HealthMate™ Coast to Coast Provider Network Directory to determine whether or not your health care *provider* is a member of Blue Cross & Blue Shield of Rhode Island's designated *BlueCard* PPO *network*, Preferred Blue. If you travel outside the Blue Cross & Blue Shield of Rhode Island service area and need information on the nearest PPO *doctors* and *hospitals*, call *BlueCard* Access at the number shown on your ID card. For more information on receiving services outside of the service area, see Section 4.3.

If you have questions or issues regarding your *benefits* under this agreement, call the Blue Cross & Blue Shield of Rhode Island (BCBSRI) Customer Service Department at (401) 459-5000 or 1-800-639-2227. Our normal business hours are Monday - Friday from 8:00 a.m. - 8:00 p.m. and Saturday from 8:00 a.m. - 2:00 p.m. If you call after normal business hours, our answering service will document your call and a BCBSRI Customer Service Representative will return your call on the next business day. When you call, identify yourself as a *subscriber* and have your *member* ID number ready. Below are a few examples of when you should call our Customer Service Department:

- To learn if a *provider* participates with Blue Cross & Blue Shield of Rhode Island's designated *BlueCard* PPO *network*.
- To file a *complaint* or *administrative appeal* (See Section 6.2 for a description of this process).

- To file an appeal regarding a medical necessity determination or learn about the status of your appeal process (See Section 6.3 for a description of this process).

If you travel outside the Blue Cross & Blue Shield of Rhode Island service area and need medical care, call *BlueCard* Access at 1-800-810-BLUE (2583) for information on the nearest PPO *doctors* and *hospitals*. You can also visit the *BlueCard* PPO Doctor and Hospital finder web page at www.bcbs.com

Services for which *preauthorization* is recommended are marked with an asterisk (*) in the Summary of Benefits. To obtain *preauthorization* for a *covered health care service:*

- For all *covered health care services* (except mental health and *chemical dependency*) provided by *non-network providers* or by another Blue Cross plan's designated *BlueCard* PPO *providers* call our Customer Service Department.
- For mental health and *chemical dependency* services provided by *non-network providers* or by another Blue Cross plan's designated *BlueCard* PPO *providers* call 1-800-274-2958 prior to receiving care. Lines are open 24 hours a day, 7 days per week.

To find out all the latest Blue Cross & Blue Shield of Rhode Island news and *plan* information, visit our Web site at BCBSRI.com

1.6 Your Right to Choose Your Own Provider

Your relationship with your *provider* is very important. This agreement is intended to encourage the relationship between you and your *provider*. However, we are neither obligated to provide you with a *provider*, nor are we liable for anything your *provider* does or does not do. We are not a health care *provider* and we do not practice medicine, furnish health care, or make medical judgments. We review *claims* for payment to determine whether the *claims* were properly authorized, constitute *medically necessary* services for the purpose of benefit payment, and are *covered health care services* under this agreement. The determination by us of whether a service is *medically necessary* is solely for the purpose of *claims* payment and the administration of health *benefits* under this agreement, and not an exercise of professional medical judgment.

1.7 Our Right to Receive and Release Information About You

We are committed to maintaining the confidentiality of your health care information. However, in order for us to make available quality, cost-effective health care coverage to you, we may release and receive information about your health, treatment, and/or condition to or from authorized *providers* and insurance companies, among others. We may release or receive this information as permitted by law for certain purposes, including, but not limited to:

- adjudicating health insurance *claims*;
- administration of *claim* payments;
- health care operations;
- case management and *utilization review*; and
- coordination of health care *benefits* provided.

Our release of information about you is regulated by law. For more information, please see the Rhode Island Confidentiality of Health Care Communications and Information Act, §§ 5-37.3-1 et seq. of the Rhode Island General Laws, the Health Insurance Portability and Accountability Act Final Privacy Regulations, 45 C.F.R. §§ 160.101 et seq., the Gramm-Leach-Bliley

Financial Modernization Act, 15 U.S.C. §§ 6801-6908, and Regulation 100 adopted by the Rhode Island Department of Business Regulation.

1.8 Our Right to Approve Alternative Benefits

We have the right to cover *benefits* not listed in this agreement as alternatives to covered *benefits*. We must pre-approve all alternatives for each individual. We do not make alternatives available to all *members* or to any *member* a second time without additional approval. Alternatives must be consistent with our goals to offer cost-effective health care *benefits*. Any decisions to cover or not to cover alternative *benefits* are within our sole discretion, and any decision not to approve alternative *benefits* made by us in good faith is binding upon you.

1.9 Our Right to Conduct Utilization Review

To ensure a *member* receives appropriate *benefits*, we reserve the right to conduct *utilization review* or to contract with an organization to conduct *utilization review* on our behalf. If another company performs *utilization review* on our behalf, such company will act as an independent contractor and not a partner, agent, or employee of Blue Cross & Blue Shield of Rhode Island. This agreement provides coverage for only *medically necessary* care. The determination by an entity conducting *utilization review* of whether a service is *medically necessary* is solely for the purpose of *claims* payment and the administration of your health benefit *plan*, and is not a professional medical judgment. Although we may conduct *utilization review*, Blue Cross & Blue Shield of Rhode Island does not act in the capacity of a health care *provider*, does not furnish medical care and does not make medical judgments. You are not prohibited from undergoing a treatment or hospitalization for which reimbursement has been denied, and nothing herein shall alter or affect your relationship with your *provider(s).*

2.0 ELIGIBILITY

Section 2.0 of this agreement describes rules for who is eligible for coverage, how *eligible persons* are enrolled, and how and when coverage may be terminated.

2.1 Who is Eligible for Coverage

You: You are eligible to apply for coverage under this agreement if:

- you are not eligible for coverage under Medicare, TRICARE, or similar federal programs;
- you are not eligible for employer-sponsored group coverage or similar coverage;
- you have exhausted any *COBRA* benefit available to you; AND
- you reside in Rhode Island.

Your Spouse: Only one of the following persons can be considered eligible to enroll under family coverage with you at the same time:

- Spouse: Your lawful spouse, according to the statutes of the state in which you were married, is eligible to enroll for coverage under this agreement.
- Former Spouse: In the event of a divorce, your former spouse will continue to be eligible for coverage provided that your divorce decree requires you to maintain continuing coverage under a family policy in accordance with state law. In that case, your former spouse will remain eligible on your policy until the earlier of:
  i. the date either you or your former spouse are remarried;
  ii. the date provided by the judgment for divorce; or
  iii. the date your former spouse has comparable coverage available through his or her own employment.
- Common Law Spouse: Your spouse by common law of the opposite gender is eligible to enroll for coverage under this agreement if you and your Common Law Spouse complete and sign our Affidavit of Common Law Marriage and we receive the necessary proof, as determined by us.

Your Children: Each of your unmarried children are eligible for coverage up to the maximum dependent age indicated in the Summary of Benefits, or as ordered by a Qualified Medical Child Support Order ("QMCSO"). For purposes of determining eligibility under this agreement, the term Child means:

- Natural Children
- Stepchildren
- Legally Adopted Children: In accordance with Rhode Island General Law § 27-20-14, an adopted child will be considered eligible for coverage as of the date of placement for adoption with you by a licensed child placement agency.
- Foster Children: Your foster children who permanently reside in your household are eligible to enroll for coverage under this agreement.

You must provide satisfactory proof as determined by us to enroll your children.

In accordance with Rhode Island General Law § 27-20-45, when your unmarried child who is enrolled for coverage under this agreement reaches the maximum dependent child age indicated in the Summary of Benefits and is no longer considered eligible for coverage, he or she may continue to be an *eligible person* under this agreement if the child is a student or a disabled dependent:

- **Dependent Students**: Any of your unmarried children who are over the maximum dependent child age indicated in the Summary of Benefits and financially dependent upon you may continue to be eligible for coverage until the student age indicated in the Summary of Benefits if they are currently enrolled as high school students or in an academic program of study in a college, university or other post-secondary educational institution. The program of study in which your child is enrolled must lead to a certificate, diploma, degree, or other recognized evidence of completion. You will be required to recertify annually that your child continues to be a student.

- **Disabled Dependents**: If you have an unmarried child of any age who is medically certified as disabled and is chiefly dependent on you for support and care because of mental impairment or physical disability, which can be expected to result in death or can be expected to last for a continuous period of not less then twelve months, that child may be an eligible dependent under this agreement. If you have a child whom you believe satisfies these conditions, you must call us to obtain the form necessary to verify the child's disabled status and show proof of the disability. This form must be filled out and submitted to us. Periodically thereafter, you may be asked to show proof that this disabling condition still exists to maintain coverage as a dependent for this child.

2.2 When Your Coverage Begins

When First Eligible

This agreement goes into effect on the first day of the month for which we accept your application and you have paid the membership fees. This date is your anniversary date.

Under this agreement the renewal date is April 1st of each *calendar year*. This agreement will automatically renew on the renewal date as long as your membership fees are paid, except if one of the events applies from the section below entitled "When Your Coverage Ends".

We accept new *subscribers* in accordance with Rhode Island General Law §27-18.5-3. You may enroll your eligible dependents on your anniversary date, the renewal date, or during our open enrollment period. **If your dependents fail to enroll at this time, they cannot enroll in the *plan* unless they do so through a Special Enrollment Period.**

Special Enrollment

After your initial effective date, you may only enroll your eligible dependents for coverage through a Special Enrollment Period after your dependents experience either a change in family status or a loss of coverage as described below. You must make written application within the thirty-one (31) days following that event.

- Change in Family Status: Your eligible dependents will qualify for a Special Enrollment Period if you get married, or have a child born to, or placed for adoption with your family.
- Loss of Coverage: Your eligible dependents will qualify for a Special Enrollment Period by loss of coverage if each of the following conditions are met:
  - (a) The *eligible person* seeking coverage had other coverage at the time that he or she was first eligible for coverage under this agreement; and
  - (b) The person waived coverage under this *plan* due to being covered on another *plan*; and
  - (c) The coverage on the other *plan* is terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death,

termination of employment, or a reduction in the number of hours of employment), employer contributions towards such coverage being terminated, or if the coverage was due to *COBRA* continuation, as a result of such coverage being exhausted.

Coverage for Members who are Hospitalized on their Effective Date

If you are in the *hospital* on your effective date of coverage, health care services related to such hospitalization are covered as long as: (a) you notify us of your hospitalization within forty-eight (48) hours of the effective date, or as soon as is reasonably possible; and (b) *covered health care services* are received in accordance with the terms, conditions, exclusions and limitations of this agreement.

2.3 How to Add or Remove Coverage for Family Members

You must notify us if you want to add family *members* according to the provisions described above in Section 2.2.

You must notify us if you want to remove family *members* from your coverage. You must send notification to us and we will remove family *members* effective the first day of the month following the month in which notification was received. We must receive notice to remove your family *members* at least five (5) working days prior to the requested date of removal. If we do not receive your notice within this five working day period, you will be responsible for furnishing payment to us for another month's membership fees. Requests for retroactive removal of family *members* will NOT be allowed.

2.4 When Your Coverage Ends

When We End This Agreement

This agreement will end automatically:

(a) on the date membership fees due are not paid;

(b) the first day of the month following that month in which you cease to be an *eligible person*;

(c) the first day of the month following that month in which you are no longer a Rhode Island resident;

(d) the date fraud is determined by us. Fraud includes, but is not limited to, misuse of your identification card and any misrepresentation made by you or on your behalf that affects your coverage. Fraud may result in retroactive termination, and you will be responsible for all costs incurred by Blue Cross & Blue Shield of Rhode Island as a result of the fraud. Furthermore, Blue Cross & Blue Shield of Rhode Island at its discretion may decline your reinstatement under your direct pay coverage, or any other coverage that may become available in the future;

(e) the date abuse or disregard for *provider* protocols and policies is determined by us. If after making a reasonable effort physicians are unable to establish or maintain a satisfactory relationship with a *member*, coverage may be terminated after 31-days' written notice. Examples of unsatisfactory physician-patient relationships include abusive or disruptive behavior in a physician's office, repeated refusals by a *member* to accept procedures or treatment recommended by a physician, and impairing the ability of the physician to provide care; OR

(f) if we cease to offer this type of coverage, pursuant to the rights and limitations of Rhode Island General Law §27-18.5-4.

This agreement will end for a covered dependent if the dependent no longer qualifies as an eligible dependent.

Reinstatement
We may reinstate coverage under this agreement at our discretion if you (a) make written appeal to us and (b) pay any required premiums within forty-five (45) days of the premium due date. Required premiums include any overdue premiums and any premiums currently billed.

When You End This Agreement
You may end this agreement by notifying us in writing that you want to discontinue coverage.

We must receive your notice to end this agreement at least five (5) working days prior to the requested date of cancellation. If we do not receive your notice within this five (5) day period, you will be responsible for another month's family membership fees. Requests for retroactive cancellations will NOT be allowed.

2.5 Continuation of Coverage

Extended Benefits
In the event that we cancel or refuse to renew this agreement, *benefits* shall be extended as to pregnancy which commenced while the agreement was in force and for which benefits would have been payable had the agreement remained in force.

If you are disabled on the termination date of this agreement, your benefits will be temporarily extended for any continuous loss which commenced while the agreement was in force. The extension of benefits will cease upon the earliest of the following events:
(a) the continuous disability ends; or
(b) twelve (12) months from the termination date; or
(c) payment of the *maximum benefits* under this agreement has been met.

The services provided under this benefit are subject to all terms, conditions, limitations and exclusions listed in this agreement, and the care you receive must relate to or arise out of the disability you had on the day this agreement ended.

Extended benefits apply ONLY to the *subscriber* who is disabled. If you desire to receive coverage for continued care upon termination of this agreement, you must provide us with proof that you are disabled. We have the right and discretionary authority to determine whether your condition constitutes a disability and any such determination made by us in good faith is binding upon you.

3.0 COVERED HEALTH CARE SERVICES

We agree to provide coverage for *medically necessary covered health care services* listed in this agreement. If a service or category of service is not specifically listed as covered, it is not covered under this agreement. Only services that we have reviewed and determined are eligible for coverage under this agreement are covered. All other services are not covered. See Section 1.2 for how we identify *new services* and our guidelines for reviewing and making coverage determinations.

We only cover a service listed in this agreement if we determine that it is *medically necessary*. The term *medically necessary* is defined in Section 7.0 - Glossary. It does not include all medically appropriate services.

The amount of coverage we provide for each health care service differs according to whether or not the service is received:

(a) as an *inpatient*;
(b) as an *outpatient*;
(c) in your home; or
(d) in a *doctor's* office.

Also coverage differs depending on whether or not:

(a) the health care *provider* is a *network provider* or *non-network provider;*
(b) *deductibles, copayments,* and/or *maximum benefit* apply;
(c) you have reached your *calendar year maximum out-of-pocket expense*; or
(d) there are any applicable exclusions from coverage.

Please see the Summary of Benefits at the front of this agreement to determine the amount of coverage we provide for *covered health care services* under this agreement.

3.1 Ambulance Services

Ground Ambulance

Local professional or municipal ground ambulance services are covered up to the benefit limits and level of coverage listed in the Summary of Benefits when it is *medically necessary* to use these services, rather than any other form of transportation, to the following destinations:

(a) to the closest available *hospital* for an *inpatient* admission;
(b) from a *hospital* to home or to a skilled nursing facility after being discharged as an *inpatient;*
(c) to the closest available *hospital* emergency room immediately in an *emergency*; OR
(d) to and from a *hospital* for *medically necessary* services not available in the facility where you are an *inpatient*.

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

Air/Water Ambulance

Medically necessary air and water ambulance services are covered up to the *maximum benefit* limit and level of coverage listed in the Summary of Benefits. When you receive services from a *network provider* you are responsible to pay the *deductible*, *copayment*, and the difference between our *allowance* and the *maximum benefit* limit. You are responsible to pay up to the total *charge* when a *non-network provider* renders air/water ambulance services.

Air ambulance service involves transportation by means of a helicopter or fixed wing aircraft. The aircraft must be a certified ambulance and the crew, maintenance support crew and aircraft must meet the certification requirements and hold a certificate for air ambulance operators under Part 135 of the Federal Aviation Administration (FAA) regulations.

Water ambulance involves transportation by a boat. The boat must be specially designed and equipped for transporting the sick or injured and it must also have such other safety and lifesaving equipment as is required by state or local authorities.

Use of an air/water ambulance is *medically necessary* when the time needed to transport a patient by land, or the instability of transportation by land, poses a threat to the patient's condition or survival or the proper equipment required to treat the patient is not available on a land ambulance.

The patient must be transported for treatment to the nearest appropriate facility that is capable of providing a level of care for the patient's illness and that has available the type of physician or physician specialist needed to treat the patient's condition.

We will only cover air and water ambulance services originating and terminating in the United States and its territories. Our *allowance* for the air/water ambulance includes the services rendered by an emergency medical technician or paramedic, drugs, supplies and cardiac monitoring.

Related Exclusions

This agreement does NOT provide coverage for air/water ambulance transportation unless the destination is an acute care *hospital*. Examples of non-covered air/water ambulance include transportation to a physician's office, nursing facility, or a patient's home.

This agreement does NOT provide coverage for transport from cruise ships when not in United States waters.

3.2 Behavioral Health Services

Behavioral health services are the evaluation, management, and treatment of a patient with a mental health or *chemical dependency* problem.

A. Mental Health Services

Inpatient

If you are an *inpatient* in a *general* or *specialty hospital* for mental health services, we cover *hospital services* and the services of an attending physician for the number of *hospital* days shown in the Summary of Benefits. See Section 3.17 - *Hospital Services*.

Outpatient/In a Provider's Office/In your Home

We cover the following *outpatient* mental health specialists:

- Board certified psychiatrists;
- Licensed clinical psychologists;
- Clinical social workers (licensed or certified at the independent practice level);
- Licensed nurse clinicians (with a masters degree in nursing and certification by the ANA as a clinical specialist in psychiatric and mental health nursing);

- Licensed mental health counselor; AND
- Licensed marriage and family therapists.

The above *providers* must be licensed and certified in the state where you receive the service and must meet our credentialing criteria.

Covered mental health services include individual psychotherapy, group psychotherapy, and family therapy when rendered by a mental health specialist, as listed above. See the Summary of Benefits for benefit limits and level of coverage.

For the purpose of coverage under this agreement, *outpatient* medication visits are not subject to the *outpatient* mental health visit maximum. We cover *outpatient* medication visits when rendered by a psychiatrist or a licensed nurse clinician. The applicable specialist office visit *copayment* and/or *deductible* will apply. See the Summary of Benefits for benefit limits and level of coverage. See Section 3.24 – Office Visits.

Intermediate Care Services
Intermediate Care Services are facility based *outpatient programs* used as a step down from a higher level of care or a step-up from standard *outpatient* care. See the Summary of Benefits for benefit limits and level of coverage. *Preauthorization* is recommended for intermediate care services.

We cover the following mental health Intermediate Care Services:

- **Partial Hospital Program (PHP)** – We cover partial *hospital programs* that are approved by us and meet our criteria for participation. This *program* must be available for a minimum of six (6) hours per day five (5) days per week and must consist of, but not limited to, group, individual, and family therapy, medication evaluation and management services, and must be available 24 hours a day 7 days per week for support of the patient. This *program* must provide substantial clinical support to patients who are either in transition from the *hospital* to an *outpatient* setting or at risk for admission to *inpatient* care or other higher levels of care.

- **Intensive Outpatient Program (IOP)** – We cover intensive *outpatient programs* that are approved by us and meet our criteria for participation. This *program* must be available for a minimum of three (3) hours per day, three (3) days per week and must consist of, but not limited to, individual, group, and family therapy, medication evaluation and management services, and must be available 24 hours a day 7 days per week for support of the patient. This *program* must provide substantial clinical support for patients who are either in transition from the *hospital* to an *outpatient* setting or at risk for admission to *inpatient* care or other higher levels of care.

- **Adult Intensive Service (AIS)** – We cover adult intensive services that are approved by us and meet our criteria for participation. AIS is a facility based mental health care *program*. Adult intensive services are primarily based in the home for qualifying adults with moderate to severe psychiatric conditions. This *program* must consist of, but is not limited to, ongoing *emergency*/crisis evaluations that are available 24 hours a day 7 days per week, psychiatric assessment, medication evaluation and management, case management, psychiatric nursing services, and individual, group, and family therapy. The *program* requires the health care *provider* to render a minimum of six (6) contact

hours per week. The benefit limit for this *program* is a maximum of ten (10) weeks or seventy (70) days per *calendar year*.

- **Child and Family Intensive Treatment (CFIT)** – We cover child and family intensive treatment services that are approved by us and meet our criteria for participation. CFIT is a facility based mental health care *program*. The *program* is primarily based in the home for qualifying children with moderate to severe psychiatric conditions. CFIT services must consist of, but are not limited to individual, family, and group counseling; medication consultation and management; and case management coordination with a school, state agency, *outpatient providers*, and/or physicians. The *program* requires the health care *provider* to render a minimum of six (6) contact hours per week. The benefit limit for this *program* is a maximum of ten (10) weeks or seventy (70) days per *calendar year*. CFIT benefits are available only for covered dependent children until their nineteenth (19th) birthday.

Electroconvulsive Therapy - We will cover electroconvulsive therapy (ECT) services when performed and billed by a psychiatrist. Our *allowance* includes all services performed by the ECT *provider* on the same day. We cover anesthesia services when rendered by an anesthesiologist. See Section 3.36 Surgery Services - Anesthesia Services.

Related Exclusions

This agreement does NOT cover the following mental health services:

- Treatment for mental disorders and illnesses which, according to general medical standards, cannot be effectively treated.
- Recreation therapy, non-medical self-care, or self-help training.
- Mental health residential treatment *programs*, services performed in a residential treatment facility, or a portion of a *hospital* used for residential treatment purposes.
- Mental health visits on the same day ECT was performed.

Any determination made by us in good faith that a service constitutes recreation therapy, non-medical self-care, or self-help training is binding on you.

B. Chemical Dependency Treatment

If any provisions of Section 3.17 - *Hospital Services* are different from the provisions of this section, the provisions of this section shall apply and govern for *inpatient* or *outpatient chemical dependency* treatment.

We cover *medically necessary* services for the treatment of *chemical dependency* in a *network hospital, chemical dependency treatment facility,* or a community residential facility.

In order for a facility to be a *network provider,* the facility must meet specific requirements including, but not limited to, the following:

(a) The *provider* must be licensed under the laws of the State of Rhode Island or by the state in which the facility is located as a *hospital,* a *chemical dependency treatment facility*, or a community residential facility for *chemical dependency* treatment; AND

(b) The *provider* must sign an agreement to provide covered *chemical dependency* services.

Related Exclusions

This agreement does NOT cover *chemical dependency* treatment when the *provider* does NOT meet the eligibility and/or credentialing requirements. This agreement does NOT cover treatment at facilities that are not approved and/or licensed by the state in which the facility is located. See Section 5.6 for Services Provided by Facilities We Have Not Approved and Section 5.8 for Services Performed by People/Facilities Who Are Not Legally Qualified or Licensed.

Inpatient

We cover the following *inpatient chemical dependency* services:

- *Inpatient* detoxification up to the maximum number of days listed in the Summary of Benefits.
- Intensive Rehabilitation/Residential treatment up to the maximum number of days listed in the Summary of Benefits. For purposes of determining coverage, two (2) days in an *outpatient* partial *hospital program* (PHP) count as one (1) day of intensive rehabilitation/residential treatment. Three (3) days in an intensive *outpatient program* (IOP) count as one (1) day of intensive rehabilitation/residential treatment.

Outpatient/Chemical Dependency Treatment Facility/In a Provider's Office/In your Home

We cover *outpatient* services for the treatment of *chemical dependency* for individuals and family *members* covered under this agreement when rendered *outpatient* in a *hospital*, a *chemical dependency treatment facility*, a state-licensed *program* that we have approved, in a *provider's* office, or in your home. See the Summary of Benefits for benefit limits and level of coverage.

Intermediate Care Services

Intermediate Care Services are facility based *outpatient programs* used as a step down from a higher level of care or a step-up from standard *outpatient* care. See the Summary of Benefits for benefit limits and level of coverage. *Preauthorization* is recommended for intermediate care services.

We cover the following *chemical dependency* Intermediate Care Services:

- **Partial Hospital Program (PHP)** – We cover partial *hospital programs* that are approved by us and meet our criteria for participation. This *program* must be available for a minimum of six (6) hours per day five (5) days per week and must consist of, but not limited to, group, individual, and family therapy, medication evaluation and management services, and must be available 24 hours a day 7 days per week for support of the patient. This *program* must provide substantial clinical support to patients who are either in transition from the *hospital* to an *outpatient* setting or at risk for admission to *inpatient* care or other higher levels of care. (For purposes of determining coverage for *chemical dependency* treatment, two (2) days in a partial *hospital program* count as one (1) *hospital* day for *inpatient* intensive rehabilitation/residential treatment.)
- **Intensive Outpatient Program (IOP)** – We cover intensive *outpatient programs* that are approved by us and meet our criteria for participation. This *program* must be available for a minimum of three (3) hours per day, three (3) days per week and must consist of, but not limited to, individual, group, and family therapy, medication evaluation and management services, and must be available 24 hours a day 7 days per week for support of the patient. This *program* must provide substantial clinical support for patients who are either in transition from the *hospital* to an *outpatient* setting or at risk

for admission to *inpatient* care or other higher levels of care. (For purposes of determining coverage for *chemical dependency* treatment, three (3) days in an intensive *outpatient program* count as one (1) day of intensive rehabilitation/residential treatment.)

Related Exclusions

This agreement does NOT cover methadone clinics and treatments. See Section 5.6 - Services Provided By Facilities We Have Not Approved and Section 5.8 for Services Performed by People/Facilities Who Are Not Legally Qualified or Licensed.

3.3 Cardiac Rehabilitation

Inpatient

We cover cardiac rehabilitation if the *provider* and facility are specifically accredited to perform cardiac rehabilitation. See the Summary of Benefits for benefit limits and level of coverage.

Outpatient

We cover visits in a cardiac rehabilitation *program* up to the benefit limit and level of coverage shown in the Summary of Benefits if one of the following conditions is met:

- Acute myocardial infarction within the previous twelve (12) months from the start of cardiac rehabilitation.
- Following coronary artery bypass graft surgery within the preceding twelve (12) months. Cardiac rehabilitation must begin within six (6) months of the coronary artery bypass graft surgery.
- Following percutaneous transluminal coronary angioplasty.
- Following valve replacements or repairs.
- Stable angina pectoris: all patients must have had a pre-entry stress test that is positive for exercise induced ischemia within six (6) months of starting cardiac rehabilitation. The positive stress test should include perfusion studies demonstrating the ischemia.
- Compensated heart failure.
- Post-heart transplantation.

3.4 Chiropractic Medicine

We cover *medically necessary* chiropractic visits up to the benefit limit and level of coverage as indicated in the Summary of Benefits. The benefit limit applies to any visit for the purposes of chiropractic treatment or diagnosis, regardless of the place of service. In addition, we cover selected lab tests and X-rays ordered by a chiropractic physician.

Related Exclusions

This agreement does NOT cover massage therapy, aqua therapy, maintenance therapy, and aromatherapy. Therapies, procedures, and services for the purpose of relieving stress are NOT covered. This agreement does NOT cover pillows. This agreement does NOT cover X-rays read by a chiropractic physician.

3.5 Consultations in the Hospital

If, while you are in the *hospital*, the attending *doctor* in charge of your care requests the assistance of a *doctor* who has special skills and knowledge to diagnose your condition, we cover a consultation performed by a specialist as indicated in the Summary of Benefits.

The transferring of a patient from one *doctor* to another is not considered to be a consultation. A specialized *doctor* who then treats you as his or her patient is not considered to be a consultant.

3.6 Contraceptive Drugs and Devices

In accordance with Rhode Island General Law § 27-20-43, this agreement provides coverage for all FDA approved contraceptive drugs requiring a prescription and devices requiring a prescription. The following list is based on the most current FDA approved contraceptive drugs and devices requiring a prescription and is subject to change:

- surgical insertion, removal and removal with reinsertion of contraceptive implants. Contraceptive implants are included as part of our *allowance* for the surgical insertion/reinsertion procedure. See Section 3.36 Surgery Services for how we cover surgical services.
- surgical implantation and removal of intrauterine device (IUD). The IUD is included as part of our *allowance* for the surgical implantation procedure. See Section 3.36 Surgery Services for how we cover surgical services.
- diaphragms supplied in a *doctor's* office are covered as a medical supply and subject to the level of coverage for medical equipment, medical supplies, and prosthetic devices received as an *outpatient*. See Section 3.23 Medical Equipment, Medical Supplies, and Prosthetic Devices.
- injectable contraceptive prescription drugs supplied and administered by a *doctor* are covered as an injectable prescription drug dispensed and administered by a licensed health care *provider* (other than a pharmacist). See Section 3.29 Prescription Drugs.
- prescribed oral contraceptives, contraceptive patches, diaphragms, and injectable contraceptive prescription drugs purchased at a *network pharmacy* are covered as a prescription drug purchased at a pharmacy. See Section 3.29 Prescription Drugs.

See the Summary of Benefits for benefit limits and level of coverage for each section.

Related Exclusions

A church or qualified church-controlled organization as defined in 26 USC 3121 may opt to exclude coverage for contraceptive drugs and devices. See Summary of Benefits to determine coverage of contraceptive drugs and devices, if any.

3.7 Diabetic Equipment/Supplies

In accordance with Rhode Island General Law § 27-20-30, this agreement provides coverage for the following *medically necessary* diabetic equipment and supplies, subject to medical necessity review:

(a) therapeutic/molded shoes for the prevention of amputation are covered for the treatment of diabetes; our *allowance* for molded shoes includes the initial inserts. Additional *medically necessary* inserts for custom-molded shoes are covered; and

(b) blood glucose monitors, blood glucose monitors for the legally blind, external insulin infusion pumps and appurtenances thereto, insulin infusion devices and injection aids for the treatment of insulin treated diabetes, non-insulin treated diabetes and gestational diabetes; and

(c) insulin needles and syringes when dispensed for use with insulin, test strips for glucose monitors and/or visual reading, cartridges for the legally blind, and infusion sets for external insulin pumps for the treatment of insulin treated diabetes, non-insulin treated diabetes, and gestational diabetes.

See the Summary of Benefits for benefit limits and level of coverage.

Covered diabetic equipment/supplies purchased at a licensed medical supply *provider* are subject to the benefit limits and level of coverage listed in the Summary of Medical Benefits.

Some diabetic equipment/supplies can be purchased at a *network pharmacy*. When purchased at a *network pharmacy* the covered diabetic equipment and supplies are subject to the benefit limits and level of coverage listed in the Summary of Pharmacy Benefits. See Section 3.29 Prescription Drugs for details.

3.8 Diagnostic Imaging, Lab, and Machine Tests

Inpatient/Outpatient/In a Doctor's Office

If a *doctor* orders the following tests to diagnose a condition resulting from illness or injury, we cover the following services:

(a) Imaging including Plain film radiographs, Ultrasonography (ultrasounds), Mammograms, Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Axial Tomography (CAT or CT scans), Nuclear scans, and Positron Emission Tomography (PET scan).

This agreement provides coverage for MRIs in accordance with Rhode Island General Law §27-20-41. MRI examinations conducted outside of the State of Rhode Island must be performed in accordance with applicable laws of the state in which the examination has been conducted.

For the purpose of coverage under this agreement, *preauthorization* is recommended for the following services:

- MRI
- MRA
- CAT scans
- PET scans
- Cardiac Imaging

(b) Laboratory tests including blood tests, urinalysis, pap smears, and throat cultures.

We cover pathological examinations performed in a *hospital* only when billed by the *hospital*. Some lab tests are not covered. See the related exclusions in this section.

(c) Machine tests including Electrocardiograms (EKGs), Electroencephalograms (EEGs), Audiometric hearing tests and speech tests.

We cover services for the initial reading or initial interpretation of the diagnostic imaging, lab, and machine tests listed above.

We may conduct *utilization review* on any test to determine if the service is *medically necessary*.

For Prevention and Early Detection Services See Section 3.30.

Related Exclusions
This agreement does NOT cover re-reading of diagnostic tests by a second *doctor*.

This agreement does NOT cover the following:
- dental X-rays;
- bone marrow blood supply MRI;
- genetic testing for screening purposes;
- audiometric hearing or speech services if another entity or agency is responsible for such services under state or federal laws which provide service for the health of school children or children with disabilities. (See generally, Title 16, Chapters 21, 24, 25, and 26 of the Rhode Island General Laws and applicable regulations governing the health of school children and the special education of children with disabilities or comparable requirements established by federal law or state law of applicable jurisdiction.)

3.9 Doctors' Hospital Visits

For coverage of surgeons, see Section 3.36 - Surgery Services.

If you are admitted to *a general hospital* as an *inpatient* for a medical condition, we cover the services of a *doctor* in charge of your medical care, up to one (1) visit per day, for the same number of days allowed under Section 3.17 - *Hospital Services*. See the Summary of Benefits to determine the number of *hospital* days available.

If you are admitted for surgical, obstetrical, or radiation services, our *allowance* to the *doctors* who performed your surgery, delivered your child, or supervised your radiation includes payment for all your related *hospital* visits by these *doctors* during your admission.

If you need *inpatient* specialty care for a condition that requires skills the *doctor* in charge of your care does not have, we will cover specialist visits as *medically necessary*.

3.10 Early Intervention Services (EIS)

In accordance with Rhode Island General Law § 27-20-50, this agreement provides coverage for Early Intervention Service. Early Intervention Services are educational, developmental, health, and social services provided to children from birth to 36 months. The children must have been certified by the Rhode Island Department of Human Services to enroll in an approved Early Intervention Services *program.* Services must be provided by a licensed Early Intervention *provider* and rendered to a Rhode Island resident. We cover Early Intervention Services as defined by the Rhode Island Department of Human Services including, but not limited to, the following:
- speech and language therapy;
- physical and occupational therapy;
- evaluation;
- case management;
- nutrition;
- service plan development and review;
- nursing services; and
- assistive technology services and devices.

See the Summary of Benefits for the *maximum benefit* limit and level of coverage.

Related Exclusions

This agreement does NOT cover early intervention services when the services are provided by a non-licensed early intervention *provider* or the services are rendered to a non-Rhode Island resident.

3.11 Emergency Room Services

Hospital

We cover emergency room services only for an *emergency*. See Section 7.0 for the definition of an *emergency*. If your condition requires immediate or urgent, but non-*emergency* care, contact your *doctor* or use an *urgent care center.*

If you have an accident or medical *emergency* that requires emergency room services and your first visit to the emergency room occurs within twenty-four (24) hours of the accident or onset of symptoms, we cover the *hospital* or emergency room services and the *doctor's* services. See the Summary of Benefits for benefit limits and level of coverage.

Bandages, crutches, canes, collars, and other supplies incidental to your treatment in the emergency room are covered as part of our *allowance* for the emergency room services. See the Summary of Benefits for benefit limits and level of coverage.

If you are admitted to a *non-network hospital* from the emergency room to receive *inpatient* services, you must inform us of the *emergency* within twenty-four (24) hours, or as soon as reasonably possible. Call our Customer Service Department at (401) 459-5000 or 1-800-639-2227.

Accident includes an accidental injury to your *sound natural teeth*. Accidental injuries are those caused by unexpected and unintentional means. If you receive treatment in an emergency room for an accidental injury to your *sound natural teeth*, and/or any facial fractures, and the injury is the direct cause, independent of disease or bodily injury, we cover the *hospital* or emergency room services and the *doctor's* services. If you receive these services in a *doctor*/dentist's office, you are responsible for any applicable office visit *copayment* and/or *deductible*. See Section 3.24 - Office Visits. Only the following services are covered when received within seventy-two (72) hours of the onset of an accidental injury to your *sound natural teeth*:

- Extraction of teeth needed to avoid infection of teeth damaged in the injury;
- Suturing;
- Reimplanting and stabilization of dislodged teeth;
- Repositioning and stabilization of partly dislodged teeth; and
- Medication received from the *provider*.

Suture removal performed where the original *emergency* medical or dental services were received is covered as part of our *allowance* for the original *emergency* treatment. We will ONLY cover a separate charge for suture removal if the suturing and suture removal are performed at different locations (i.e. sutures at emergency room and suture removal at *doctor's* office).

Related Exclusions

This agreement does NOT cover:

- *hospital* or other facility's services for treatment received in an emergency room for a non-*emergency* condition;
- follow-up visits to the emergency room;
- dental injuries incurred as a result of biting and/or chewing; or
- any dental services other than those specifically listed above for injury to your teeth.

3.12 Experimental/Investigational Services

This agreement only provides coverage for *experimental/investigational* services as required by Rhode Island General Laws Sections § 27-20-27 et seq. concerning New Cancer Therapies and as required by Rhode Island General Laws Title 27, Chapter 55, entitled "Off Label Use of Prescription Drugs".

Related Exclusions

This agreement does NOT cover any treatments, procedures, facilities, equipment, drugs, devices, supplies, or services that are *experimental* or *investigative*.

Recognition as having been proven effective in clinical medicine shall only be obtained through the following:

- Final approval for the use of a specific service for a specific condition from the appropriate governmental regulatory body; OR
- Demonstrated, reliable evidence based upon an entry in at least one of the three standard reference compendia set forth in subsection 4 (c) of this Section 3.12 based upon sound scientific studies published in authoritative, peer reviewed medical journals that illustrate statistically significant outcomes about the effectiveness of the service, and that permit a consensus of opinion that the service improves the net health outcome, is as beneficial as any established alternatives and that said improvement is attainable outside the *investigational* setting.

The determination by an expert medical consultant retained by us, for the purpose of reviewing a particular service, that the service is not *experimental/investigational* for that particular case.

A service is considered "*experimental/investigational*," if we determine that one or more of the following circumstances are true:

(1) The service is the subject of ongoing phase I or phase II clinical trial or is the *experimental* arm of phase III clinical trial or is under study to determine the maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

(2) The prevailing opinion among experts regarding the service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or

(3) The current belief in the pertinent specialty of the medical profession in the United States is that the service or supply should not be used for the diagnosis or indications being requested outside of clinical trials or other research settings because it requires further evaluation for that diagnosis or indications. We will determine the applicability of this criterion based on:

(a) Published reports in authoritative, peer-reviewed medical literature; AND
(b) Reports, publications, evaluations, and other sources published by government agencies, such as the National Institutes of Health, the FDA, and the Agency for Healthcare Research and Quality; or

(4) If the benefit in question is a drug, a device, or other supply that is subject to approval by the FDA, at least one of the following criteria will apply:
(a) it has not received FDA approval; or
(b) it has limited FDA approval under regulations such as Treatment Investigational New Drugs; or
(c) it has FDA approval but the indication for the drug or device, or the dosage, is not an accepted off-label use. We will judge this criterion through review of reports published in authoritative peer-reviewed United States medical literature OR entries in one or more of the following drug compendia:
i. The AMA Drug Evaluations;
ii. The American Hospital Formulary Service Drug Information;
iii. The U.S. Pharmacopoeia Dispensing Information; or

(5) The Institutional Review Board (IRB) of the *provider* of the service or supply acknowledges that use of it is *experimental/investigational* and is subject to the approval of the IRB; or

(6) The *provider* IRB requires the patient (or parent or guardian) to give an informed consent for the service or supply that states the service or supply is *experimental/investigational*, or federal law requires such a consent; or

(7) The research protocols related to the requested service or supply state or indicate the service or supply is *experimental/investigational*.

We have the right and discretionary authority to determine whether a service is *experimental/investigational*, and any such determination made by us in good faith is binding on you.

3.13 Hemodialysis Services

Inpatient

Inpatient hemodialysis services are covered as a *hospital service*. See Section 7.0 - definition of *hospital services.*

Outpatient

If you receive hemodialysis services in a *hospital's outpatient* unit or in a hemodialysis facility, we cover the use of the treatment room, related supplies, solutions, and drugs, and the use of the hemodialysis machine.

In Your Home

If you receive hemodialysis services in your home and the services are under the supervision of a *hospital* or *outpatient* facility hemodialysis *program*, we cover the purchase or rental (whichever is less, but never to exceed our *allowance* for purchase) of the hemodialysis machine, related supplies, solutions, and drugs, and necessary installation costs.

Related Exclusions

If you receive hemodialysis services in your home, this agreement does NOT cover installation or modification of electric power, water and sanitary disposal or *charges* for these services,

moving expenses for relocating the machine, installation expenses not necessary to operate the machine or to train you or *members* of your family in the operation of the machine.

This agreement does NOT cover hemodialysis services when received in a *doctor's* office.

3.14 Hemophilia Services

Outpatient/In a Doctor's Office

We cover the following *medically necessary* services for treatment of hemophilia:

- yearly evaluation;
- office visits;
- hemophilia *outpatient* physical therapy;
- clotting factor drugs; and
- supplies.

3.15 Home Health Care

In Your Home

If you qualify to receive health care at home, we cover home health care services provided by a *hospital* or community home health care agency. We cover the following *medically necessary* services:

- nurse services;
- services of a home health aide;
- visits from a social worker; and
- physical and occupational therapy.

For information regarding *doctor* home and office visits See Section 3.18 - House Calls and Section 3.24 - Office Visits, for home care equipment and supplies See Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices, for radiation therapy or chemotherapy services See Section 3.31 - Radiation Therapy/Chemotherapy Services, and for medications See Section 3.29 – Prescription Drugs.

See the Summary of Benefits for benefit limits and level of coverage for each section.

Related Exclusions

This agreement does NOT cover any homemaking, companion, or chronic (custodial) care services.

This agreement does NOT cover:

- *charges* for private duty nursing when primary duties are limited to bathing, feeding, exercising, homemaking, giving oral medications or acting as companion/ sitter; OR
- services of a private nurse who is a *member* of your household or the cost of any care provided by one of your relatives (by blood, marriage or adoption).

3.16 Hospice Care

Inpatient

If you have a terminal illness and you agree with your *doctor* not to continue with a curative treatment program, we cover *inpatient* hospice care admissions. See Section 7.0 - definition of *hospital services.*

Related Exclusions
This agreement does NOT cover custodial care, respite care, day care, or care in a facility that is not approved by us. See Section 5.6 - Services Provided by Facilities We Have Not Approved.

In Your Home
If you have a terminal illness and you agree with your *doctor* not to continue with a curative treatment program, we cover some hospice care services provided by a hospice care *program*, as set forth in this section. We cover the following:

- services of a hospice coordinator billed by the hospice care *program*;
- services of grief counselors and pastoral care;
- services of a social worker;
- services of a nurse; and
- services of a home health aide.

For information regarding *doctor* home and office visits See Section 3.18 - House Calls and Section 3.24 - Office Visits, hospice care equipment and supplies See Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices, and for medications See Section 3.29 - Prescription Drugs.

See the Summary of Benefits for benefit limits and level of coverage for each section.

3.17 Hospital Services

Inpatient
Semi-Private Room Charges/Days of Hospital Coverage
If you are hospitalized as an *inpatient* in a ward or *semi-private room* in *a general hospital* for medical or surgical services, we cover *hospital services* for the number of days listed in the Summary of Benefits.

Coverage for physical rehabilitation services received in *a specialty hospital* or in *a general hospital* is limited to the number of days listed in the Summary of Benefits.

If you are readmitted to the same or any other *hospital* within ninety (90) days after the date of a previous discharge, we will consider these admissions to fall within the same period of hospitalization when determining the number of *hospital* days available to you.

If you are readmitted after ninety (90) days, we consider this to be a new period of hospitalization for the purpose of determining the *hospital* days available to you.

Hospital services and *free-standing ambulatory surgi-center* services provided in connection with a dental service are covered when the use of the *hospital* or *free-standing ambulatory surgi-center* is *medically necessary* and the setting in which the service received is determined to be appropriate. *Preauthorization* is recommended for this service. **The dental services will remain non-covered See Section 5.17.**

Related Exclusions
This agreement does NOT cover extra *charges* for a private room.

3.18 House Calls

We cover *doctor* visits in your home if you have a condition resulting from an injury or illness which confines you to your home, requires special transportation, or requires the assistance of another person. See the Summary of Benefits for benefit limits and level of coverage.

3.19 Human Leukocyte Antigen Testing

In accordance with Rhode Island General Law § 27-20-36, we cover human leukocyte antigen testing for A, B, and DR antigens once per *member* per lifetime for utilization in bone marrow transplantation. The testing must be performed in a facility which is:

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

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

3.20 Infertility Services

Inpatient/Outpatient/In a Doctor's Office

In accordance with Rhode Island General Law § 27-20-20, this agreement provides coverage for *medically necessary* services for the diagnosis and treatment of infertility. We cover donor gametes if provided through a *program*. We only cover these services if you are:

- married;
- unable to conceive or produce conception during a one (1) year period; AND
- a presumably healthy individual.

Infertility services**,** including prescription drug coverage, are covered up to the benefit limit and level of coverage listed in the Summary of Benefits. Infertility prescription drug coverage is based on the route of administration and site of service. See Section 3.29 - Prescription Drugs for details and the Summary of Pharmacy Benefits for benefit limits and level of coverage.

Related Exclusions

This agreement does NOT cover infertility treatment for an individual that previously had a voluntary sterilization procedure.

3.21 Infusion Therapy

Inpatient

Inpatient infusion therapy services are covered as a *hospital service*. See Section 7.0 - definition of *hospital services.*

Outpatient

If you receive infusion therapy services in a *hospital's outpatient* unit, we cover the use of the treatment room, related supplies and solutions. For prescription drug coverage see Section 3.29 – Prescription drugs.

See the Summary of Benefits for benefit limits and level of coverage.

In a Doctor's Office
If you receive infusion therapy services in a *doctor's* office, we cover the related supplies, solutions. For prescription drug coverage see Section 3.29 – Prescription Drugs.

See the Summary of Benefits for benefit limits and level of coverage.

In Your Home
We cover the following infusion therapy services as part of our *allowance* for home infusion therapy services when provided by an agency approved by us:

- nursing visits;
- administration of infusions for therapeutic delivery of drugs, biologicals, and hydration;
- infusions for total parenteral nutrition (including the infused TPN);
- related equipment; and
- supplies.

For information regarding *doctor* home and office visits See Section 3.18 - House Calls and Section 3.24 - Office Visits, home care equipment and supplies See Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices, radiation therapy or chemotherapy services See Section 3.31 - Radiation Therapy/Chemotherapy Services, and for medications See Section 3.29 – Prescription Drugs.

See the Summary of Benefits for benefit limits and level of coverage for each section.

Related Exclusions
This agreement does NOT cover any homemaking, companion, or chronic (custodial) care services.

3.22 Lyme Disease Diagnosis and Treatment

In accordance with Rhode Island General Law § 27-20-48, coverage is provided for diagnostic testing and long-term antibiotic treatment of chronic lyme disease when determined *medically necessary*. To qualify for payment, services must be ordered by your *doctor* after evaluation of your symptoms, diagnostic test results, and response to treatment. Benefit payment for lyme disease treatment will not be denied solely because such treatment may be characterized as unproven, *experimental*, or *investigational*.

For coverage of specific services, refer to Sections 3.8 – Diagnostic Imaging, Lab, and Machine Tests, 3.24 - Office Visits, 3.21 Infusion Therapy, and 3.29 – Prescription Drugs.

3.23 Medical Equipment, Medical Supplies, and Prosthetic Devices

Coverage is provided for *durable medical equipment, medical supplies,* and *prosthetic devices* that meet the minimum specifications which are *medically necessary*.

The *provider* must meet eligibility and/or credentialing requirements as defined by the *plan* to be eligible for reimbursement.

DURABLE MEDICAL EQUIPMENT is equipment (and supplies necessary for the effective use of equipment) which:
(a) can withstand repeated use;
(b) is primarily and customarily used to serve a medical purpose;

(c) is not useful to a person in the absence of an illness or injury; and
(d) is for use in the home.

MEDICAL SUPPLIES means those consumable supplies which are disposable and not intended for re-use. Medical supplies require an order by a physician and are essential for the care or treatment of an illness, injury, or congenital defect.

PROSTHETIC DEVICES means devices (other than dental) which replace or substitute all or a part of an internal body part (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning body part necessary to alleviate an illness, injury or congenital defect.

Inpatient
Inpatient medically necessary durable medical equipment, medical supplies, and prosthetic devices you receive as an *inpatient* when provided and billed for by the *hospital* where you are an *inpatient* are covered as a *hospital service*. See Section 7.0 for the definition of *hospital services*. *Hospital Services* are covered up to the benefit limits and level of coverage shown in the Summary of Benefits.

When a *provider*, other than a *hospital* as mentioned above, bills for a *medically necessary prosthetic device* you receive as an *inpatient* the benefit limits and level of coverage shown in the Summary of Benefits for Medical Equipment, Medical Supplies, and Prosthetic Devices will apply.

Outpatient/In Your Home
See the Summary of Benefits for benefit limits and level of coverage. We will cover the following durable medical equipment, medical supplies, and prosthetic devices subject to our guidelines:

Durable Medical Equipment
A *durable medical equipment* (DME) item may be classified as a rental item or a purchase price item, as determined by us. A DME rental item is billed on a monthly basis for a specific period of months, after which time the item is considered paid up to our *allowance.* Our *allowance* for a rental DME item will never exceed our *allowance* for a DME purchased price item. *Preauthorization* is recommended for certain items.

We will cover the following *durable medical equipment* subject to our guidelines:
(a) Wheelchairs, hospital beds, and other *durable medical equipment* used only for medical treatment.
(b) Replacement of purchased priced equipment which is required due to a change in your medical condition. Repairs and supplies to rental equipment are included in our rental *allowance. Preauthorization* is recommended for replacement and repairs of *durable medical equipment*.

Medical Supplies
We will cover the following *medical supplies* subject to our guidelines:
(a) Essential accessories such as hoses, tubes and mouthpieces for use with *medically necessary durable medical equipment* (these accessories are included as part of the rental allowance for rented equipment);

(b) Catheters, colostomy and ileostomy supplies, irrigation trays and surgical dressings;
(c) Contact lenses or glasses following cataract surgery;
(d) Diaphragms supplied in a *doctor's* office;
(e) Enteral nutrition formula and supplies to administer enteral nutrition when the nutrition is delivered through a feeding tube and is the sole source of nutrition; and
(f) Respiratory therapy equipment solutions.

Prosthetic Devices
This agreement provides coverage in accordance with Rhode Island General Law, for covered *members* up to the benefit limit and level of coverage listed in the Summary of Benefits. We will cover the following *prosthetic devices* subject to our guidelines:
(a) Prosthetic appliances such as artificial limbs, breasts, larynxes and eyes, including the replacement, repair or adjustment of these appliances (replacement of a covered device will be allowed only if there is a change in your medical condition);
(b) Devices and accessories and/or supplies necessary for attachment to and operation of *prosthetic devices*;
(c) Orthopedic braces (except corrective shoes and orthotic devices used in connection with footwear);
(d) Initial and subsequent *prosthetic devices* following a mastectomy and pursuant to an order of a physician or surgeon; and
(e) Prosthesis not supplied by the *hospital* as part of a *hospital* stay.

This agreement provides benefits for mastectomy-related prosthetics in accordance with the Women's Health and Cancer Rights Act of 1998 and Rhode Island General Laws 27-20-29 et seq. See Section 3.36 Surgery Services – Mastectomy.

Related Exclusions
Items typically found in the home and easily obtainable such as, but not limited to, band-aids, ace bandages, gauze pads, and alcohol swabs are NOT covered under this agreement.

Medical supplies provided during an office visit are included in our *allowance* for an office visit.

This agreement does NOT cover pillows, batteries, or items whose sole function is to improve the quality of life or mental well being. See Section 5.27 for a list of personal appearance and/or service items NOT covered by this agreement.

This agreement does NOT cover repair or replacement of *durable medical equipment* when the equipment is under warranty, covered by the manufacturer, or during the rental period. This agreement does NOT cover repair *charges* to repair rental items.

Hair Prosthetics (Wigs)
In accordance with Rhode Island General Law § 27-20-53, hair prosthetics (wigs) worn for hair loss suffered as a result of cancer treatment are covered up to the *maximum benefit* limit and level of coverage listed in the Summary of Benefits. When you receive services from a *network provider* you are responsible to pay the difference between our *allowance* and the *maximum benefit* limit. You are responsible to pay up to the total *charge* when a *non-network provider* renders services.

Related Exclusions
This agreement does NOT cover hair prosthetics (wigs) when worn for any condition other than hair loss suffered as a result of cancer treatment.

Hearing Aid Services
This agreement provides hearing aid coverage, in accordance with Rhode Island General Law § 27-20-46, for covered *members* up to the *maximum benefit* limit and level of coverage listed in the Summary of Benefits. When you receive services from a *network provider* you are responsible to pay the difference between our *allowance* and the *maximum benefit* limit. You are responsible to pay up to the total *charge* when a *non-network provider* provides hearing aid services.

Related Exclusions
Hearing aid coverage does NOT include batteries, repairs, modifications, cords, and other assistive listening devices.

3.24 Office Visits

The following covered preventive office visits are not subject the *calendar year deductible*:

- Adult preventive office visit rendered by your primary care physician; and
- Pediatric preventive care office visits

See the Summary of Benefits for benefit limits and level of coverage.

In a Doctor's Office
Our *allowance* for an office visit includes *medical supplies* provided as part of the office visit. See the Summary of Benefits for benefit limits and level of coverage for each service listed in this section.

Related Exclusions
Physical examinations and any services performed in conjunction with the exams, including but not limited to lab tests, machine tests, immunizations, are NOT covered when services are required for or related to employment, education, marriage, adoption, insurance purposes or when required by similar third parties.

Asthma Education
Medically necessary asthma education sessions are covered when the service is prescribed by a physician and performed by a certified asthma educator. The asthma education session can be rendered in a *doctor's* office, *outpatient* department of a *hospital*, or in a *hospital* based clinic. See the Summary of Benefits for benefit limits and level of coverage.

Other asthma related *covered health care services* including, but not limited to, office visits rendered by a *provider* (other than a certified asthma educator), medical equipment and supplies, and prescription drugs are subject to the benefit rules applicable to the specific services. For information regarding office visits See Section 3.24 - Office Visits, for medical equipment and supplies See Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices, and for medications See Section 3.29 - Prescription Drugs. See the Summary of Benefits for benefit limits and level of coverage for each section.

Diabetes Education
In accordance with Rhode Island General Law § 27-20-30, diabetes education is covered when *medically necessary* and prescribed by a physician. Such education may be provided only by a physician or, upon his or her referral to, an appropriately licensed and certified diabetes educator. See the Summary of Benefits for benefit limits and level of coverage.

Hospital Based Clinic Visits
See the Summary of Benefits for benefit limits and level of coverage. Other *covered health care services* provided by a clinic, such as physical therapy or occupational therapy, are subject to the benefit rules applicable to the specific services.

Nutritional Counseling
Medically necessary nutritional counseling is covered up to the number of visits shown in the Summary of Benefits. It must be prescribed by a physician for the purpose of treating an illness and performed by a registered dietitian/nutritionist.

Related Exclusions
Nutritional counseling is NOT covered for healthy individuals seeking nutritional information or desiring weight loss.

Office Visits (other than Pediatric Office Visits)
We cover other *medically necessary* office visits, including visits to *urgent care centers* provided they are reasonable in number and in the scope of the services rendered for the following:

- office visits to primary care physician;
- office visits to specialists;
- routine examinations;
- consultations;
- medication visits for *outpatient* mental illness, not subject to the *outpatient* mental health visit limitations; and
- office visits and/or office consultations to anesthesiologists.

See the Summary of Benefits for benefit limits and level of coverage. *Doctor* visits to your home, see Section 3.18 – House Calls.

Pediatric Office Visits
Pediatric well child exams are covered in accordance with current guidelines established by the American Academy of Pediatrics and are subject to change. See the Summary of Benefits for benefit limits and level of coverage.

3.25 Organ Transplants

Heart, heart-lung, lung, liver, small intestine, and pancreas transplants are included in the Additional Organ Transplant Coverage Section below.

Kidney, cornea, and bone marrow transplants are covered as surgical procedures. See Section 3.36 - Surgery Services.

The national transplant network program is called the Blue Quality Centers for Transplants (BQCT). For more information about the BQCT call our Case Management Department at 1-888-727-2300.

Additional Organ Transplant Coverage
We cover organ transplants for heart, heart-lung, lung, liver, small intestine, and pancreas.

The transplant benefit period for the recipient begins five days before a covered organ transplant and continues through one year afterwards. During a benefit period we cover the following services:

- covered *hospital* expenses;
- professional services for surgical, medical and other services related to a covered organ transplant; and
- additional transplant *charges* for *medically necessary* services and supplies during a transplant benefit period.

When the recipient is a covered *member* under this agreement we also cover:

- 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
- transportation of the organ from donor to the recipient.

Related Exclusions
This agreement does NOT cover:

- services or supplies related to an excluded transplant procedure;
- services related to obtaining, storing, or other services performed for the potential future use of umbilical cord blood; or
- noncadaveric small bowel transplants.

3.26 Physical/Occupational Therapy

Physical and/or occupational therapy is covered only when a *program* is implemented to restore the highest level of independent functioning in the most timely manner possible and:

- physical or occupational therapy is received from a licensed physical or occupational therapist;
- we determine that the therapy will result in significant, sustained measurable functional/anatomical improvement of your condition; and
- such improvement will not diminish with the removal of the therapeutic agent or environment.

Inpatient
Medically necessary inpatient physical or occupational therapy is covered as a *hospital service* listed in Section 7.0.

Outpatient/ In a Doctor's or Therapist's Office
We cover *medically necessary* physical and/or occupational therapy services. See the Summary of Benefits for benefit limits and level of coverage.

In Your Home
This agreement does NOT cover physical or occupational therapy services received in your home unless received through a home care *program*. See Section 3.15 - Home Health Care.

Related Exclusions
This agreement does NOT cover massage therapist services. This agreement does NOT cover these services if another entity or agency is responsible for such services under state or federal laws which provide service for the health of school children or children with disabilities. (See generally, Title 16, Chapters 21, 24, 25 and 26 of the Rhode Island General Laws and applicable regulations governing the health of school children and the special education of children with disabilities or comparable requirements established by federal law.)

3.27 Podiatrist Services

This agreement covers office visits to the podiatrist. See the Summary of Benefits for benefit limits and level of coverage.

Related Exclusions
The treatment of corns, bunions (except capsular or bone surgery), calluses, toenails (except surgery for ingrown nails), flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic foot complaints (except when surgery is performed), and routine foot care are NOT covered. Corrective or orthopedic shoes and orthotic devices used in connection with footwear are NOT covered unless related to the treatment of diabetes. See Section 3.7 – Diabetic Equipment/Supplies.

3.28 Pregnancy Services and Nursery Care

If you are covered as an individual under this agreement you must notify us and pay the appropriate family membership fee within thirty-one (31) days of delivery so that the newborn child will be covered beyond such thirty-one (31) day period. This agreement does not cover services for a newborn child who remains hospitalized after thirty-one (31) days and has not been added to a family membership. See Section 2.2 - When Your Coverage Begins - Special Enrollment.

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

- If the delivery occurs in a *hospital*, the *hospital* length of stay for the mother or newborn child begins at the time of delivery (or in the case of multiple births, at the time of the last delivery).
- If the delivery occurs outside a *hospital*, the *hospital* length of stay begins at the time the mother or newborn is admitted as a *hospital inpatient* in connection with childbirth.

Any decision to shorten these stays shall be made by the attending physician in consultation with and upon agreement with you. In those instances where you and your infant participate in an early discharge, you will be eligible for:

- Up to two (2) home care visits by a skilled, specially trained registered nurse for you and/or your infant, (any additional visits must be reviewed for medical necessity); and
- A pediatric office visit within twenty-four (24) hours after discharge.

See Section 3.18 - House Calls and Section 3.24 - Office Visits to determine coverage of home and office visits.

Additional *hospital* days may be covered ONLY if we determine that additional *hospital* days are *medically necessary*.

We cover *hospital services* provided to you and your newborn child. Your newborn child is covered for services required to treat injury or sickness. This includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities as well as routine well-baby care.

Related Exclusions
This agreement does NOT cover genetic counseling, genetic screening, or parentage testing. This agreement does NOT cover amniocentesis or any other service used to determine the sex of an infant before it is born.

Doctor Services
We cover *doctor* services (including the services of a licensed midwife) for prenatal, delivery, and postpartum services. If a *doctor* and midwife provide pregnancy services the *charges* will be combined and covered up to our *allowance*. We will not cover more than our *allowance*.

The initial office visit to diagnose pregnancy and office visits to an obstetrician or midwife unrelated to pregnancy are not included in prenatal services. They are covered as an office visit. See Section 3.24 - Office Visits.

3.29 Prescription Drugs and Diabetic Equipment/Supplies

Prescription drugs and diabetic equipment/supplies purchased at a pharmacy are administered by our Pharmacy Benefit Manager (PBM). Prescription drugs purchased at a pharmacy are subject to the benefit limits and level of coverage stated in the Summary of Pharmacy Benefits. For details see section **A. Prescription Drugs Purchased at a Pharmacy** listed below.

Prescription drugs dispensed and administered by a licensed health care *provider* (other than a pharmacy) are subject to the benefit limit and level of coverage listed in the Summary of Medical Benefits. For details see section **B. Prescription Drugs Dispensed and Administered by a Licensed Health Care *Provider* (other than a Pharmacy)** listed below.

The following definitions apply to this Section 3.29:

PHARMACY ALLOWANCE means the lower of:
(a) the amount the pharmacy *charges* for the prescription drug;
(b) the amount we or our PBM has negotiated with a *network pharmacy*; or
(c) the maximum amount we pay any pharmacy for that prescription drug.

DISPENSING GUIDELINES means:
- the prescription order or refill must be limited to the quantities authorized by your *doctor* not to exceed the quantity listed in the Summary of Pharmacy Benefits;
- the prescription must be *medically necessary*, consistent with the *doctor's* diagnosis, ordered by a *doctor* whose license allows him/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 *doctor's* prescription under law or compound medications made up of at least one *legend drug* requiring a *doctor's* prescription under law; and
- the prescription must be dispensed at the proper place of service as determined by our Pharmacy and Therapeutics Committee. For example, certain prescription drugs may only be covered when obtained from a *provider*.

Some prescription drugs are subject to additional quantity limits based on criteria that we have developed. You may obtain a current list of prescription drugs that have been assigned maximum quantity levels for dispensing by visiting our Web site at BCBSRI.com or calling our Customer Service Department at (401) 459-5000 or 1-800-639-2227.

FORMULARY means the prescription drugs and dosage forms covered under this agreement. Some prescription drugs are not in the *formulary*. A committee of local physicians and pharmacists, established by us, develop the prescription drug *formulary* listing which is subject to periodic review and modification. To obtain coverage information for a specific prescription drug or to obtain a copy of the most current *formulary* listing, visit our Web site at BCBSRI.com or call our Customer Service Department at (401) 459-5000 or 1-800-639-2227.

NETWORK PHARMACY means any pharmacy that has an agreement to accept our *pharmacy allowance* for prescription drugs and diabetic equipment/supplies covered under this agreement. All other pharmacies are **NON-NETWORK PHARMACIES**.

When you purchase covered prescription drugs and/or diabetic equipment/supplies from a ***network pharmacy,*** you will be responsible for the *deductible* listed in the Summary of Pharmacy Benefits at the time you purchase the drugs and diabetic equipment/supplies. Coverage is based on our *pharmacy allowance*.

If you purchase prescription drugs or diabetic equipment/supplies from ***non-network pharmacies***, you will be responsible to pay the charge for the prescription drug or diabetic equipment/supplies at the time the prescription is filled. This agreement does NOT cover prescription drugs or diabetic equipment/supplies when purchased at *non-network pharmacies*.

A. Prescription Drugs and Diabetic Equipment/Supplies Purchased at a Pharmacy
This section provides coverage information for prescription drugs and diabetic equipment/supplies that are purchased at a *network pharmacy*. The prescription drug must be dispensed in accordance with our *dispensing guidelines* in order to be covered.

Covered Diabetic Equipment/Supplies
The following diabetic equipment/supplies can be purchased at a *network pharmacy*:

- Glucometers
- Test Strips
- Lancet and Lancet Devices
- Miscellaneous Supplies (including alcohol swabs and calibration fluid)

See the Summary of Pharmacy Benefits for benefit limits and level of coverage.

Mail Order Pharmacy
Maintenance and non-maintenance prescription drugs and diabetic equipment/supplies may be purchased from a *network* mail order pharmacy. The prescription is limited to the benefit limit and level of coverage listed in the Summary of Pharmacy Benefits.

For mail order instructions contact our Customer Service Department.

Related Exclusions
The following items are NOT covered when obtained at a *pharmacy*:

- biological products for allergy immunizations;
- biological products for vaccinations;
- blood fractions;
- compound prescription drugs that are not made up of at least one *legend drug;*
- prescription drugs that require professional administration;
- prescription drugs prescribed or dispensed outside of our dispensing guidelines;
- prescription drugs that have not proven effective according to the FDA;
- prescription drugs used for cosmetic purposes;
- *experimental* prescription drugs (including those placed on notice of opportunity hearing status by the Federal Drug Efficacy Study Implementation (DESI);
- drugs you take or have given to you while you are a patient in a *hospital,* rest home, sanitarium, nursing home, home care *program*, or other institution that provides prescription drugs as part of its services or which operates its own facility for dispensing prescription drugs;
- non-medical substances (regardless of the reason prescribed, the intended use, or medical necessity);
- off-label use of prescription drugs (except as described in Section 3.12 *Experimental/Investigational* Services);
- over-the-counter (OTC) drugs even if prescribed, unless specifically listed as a *covered health care service* in this agreement (e.g., OTC nicotine replacement therapy);
- prescribed weight-loss drugs;
- replacement prescription drug products resulting from a lost, stolen, broken or destroyed prescription order or refill;
- support garments and other durable medical equipment;
- therapeutic devices and appliances, including hypodermic needles and syringes (except when used to administer insulin);
- Viagra or any therapeutic equivalents; OR
- Vitamins.

Prescription drugs and diabetic equipment/supplies are NOT covered when purchased from a *non-network* retail *pharmacy*.

Prescription drugs and diabetic equipment/supplies are NOT covered when purchased from a *non-network* mail order pharmacy.

Nicotine replacement therapy is NOT covered when purchased from a mail order pharmacy.

We will NOT cover a prescription drug refill if the refill is:

- greater than the refill number authorized by your *doctor;*
- greater than the twelve (12) refills we authorize;
- limited by law; or
- refilled more than a year from the date of the original prescription.

B. Prescription drugs Dispensed and Administered by a Licensed Health Care Provider (other than a Pharmacy)

Prescription drugs we have approved that are dispensed and administered by a licensed health care *provider* (other than a *pharmacy*) are covered under this agreement subject to the *copayment* and/or *deductible* listed in the Summary of Medical Benefits. The prescription drug must be dispensed in accordance with our *dispensing guidelines* in order to be covered.

Inpatient

We cover *inpatient* drugs as a *hospital service*. See Section 7.0 – definition of *hospital services*.

Outpatient/In Your Doctor's Office/In Your Home

Prescription drugs are covered at different benefit levels depending upon the route of administration. Our *allowance* for services rendered by the facilities, agencies, and professional *providers* may include the cost of the prescription drugs administered and/or dispensed. We will determine coverage based upon the route of administration that is customary and least invasive method to treat the condition. There are several ways to administer drugs into the body including:

- inhalation (into the lungs, usually through the mouth);
- intramuscular (injected into a muscle);
- intrathecal (injected into the space around the spinal cord);
- intravenous/infused/intra-arterial (into a vein or artery);
- nasal (sprayed into the nose);
- ocular (instilled in the eye);
- oral (by mouth);
- rectal or vaginal (inserted into the rectum or vagina);
- subcutaneous (injected beneath the skin);
- sublingual (under the tongue);
- topical (applied to the skin); OR
- transdermal (delivered through the skin by a patch).

Inhalation, Nasal, Ocular, Oral, Rectal Or Vaginal, Sublingual, Topical, And Transdermal Prescription Drugs

The prescription drug is included in our *allowance* for the medical service being rendered. If the sole service is drug dispensing, the prescription drug is NOT covered.

Injected Prescription Drugs

We use the term injected to include prescription drugs approved by us given by intra muscular or subcutaneous injection or in the case of a body cavity by instillation. See the Summary of Medical Benefits for benefit limits and level of coverage. See Section 3.30 Prevention and Early Detection Services for immunization and vaccination coverage information.

Infused Prescription Drugs
We use the term infused to include those prescription drugs approved by us and administered into a vein or into an artery whether by mixing in fluids and administering intravenously or into an artery, direct injection, or by use of a pump that accesses the vein or artery. See the Summary of Medical Benefits for benefit limits and level of coverage.

Anti-Neoplastic (Chemotherapy) Prescription drugs When Used For Cancer Treatment
Oral, injectable, and infused anti-neoplastic prescription drugs approved by us for the treatment of cancer are covered. This includes coverage for prescription drugs that are supportive, but not anti-neoplastic (e.g., anti-nausea prescription drugs). See the Summary of Medical Benefits for benefit limits and level of coverage.

Anti-Neoplastic (Chemotherapy) Prescription drugs When Used For Other Than Cancer Treatment
Coverage varies depending on the route of administration refer to above sections for inhalation, nasal, ocular, oral, rectal or vaginal, sublingual, topical and transdermal, injected and infused prescription drugs.

3.30 Prevention and Early Detection Services

In accordance with the guidelines established by the ACS and in accordance with Rhode Island General Laws § 27-20-17 and § 27-20-44, this agreement provides coverage for prevention and early detection services such as, but not limited to, office visits, surgical procedures, electrocardiograms, and cancer screenings. The list of covered services is based on the most current ACS guidelines and is subject to change.

Except for certain cancer screenings as mentioned below, the level of coverage for prevention and early detection services is based on the type of service. For information regarding office visits see Section 3.24- Office Visits, for surgical procedures see Section 3.36 - Surgery Services, and for lab, radiology, and machine tests see Section 3.8 - Diagnostic Imaging, Lab, and Machine Tests. See the Summary of Benefits for benefit limits and level of coverage for each type of service.

Cancer Screenings
For the purpose of coverage under this agreement, the benefit limit and level of coverage listed in the Summary of Benefits for Prevention and Early Detection Services/ Cancer Screenings applies to the following cancer screenings:
(a) Mammograms
(b) Pap Smears
(c) Prostate Specific Antigen (PSA) test

See the Summary of Benefits for benefit limits and level of coverage.

Vaccinations/Immunizations
Adult Vaccinations/Immunizations
We cover adult preventive vaccinations/immunizations for Diphtheria – Tetanus (or tetanus alone), Influenza, Pneumonia, Hepatitis A and Hepatitis B. Our *allowance* includes the administration and the vaccine. See the Summary of Benefits for benefit limits and level of coverage.

If any of the above immunizations are provided as part of an office visit, only your office visit *copayment* and/or *deductible* will be applied. If your *doctor* administers any of the above immunizations/vaccinations in the absence of an office visit, the immunization is covered up to the benefit level stated in the Summary of Benefits.

Related Exclusions
This agreement does NOT cover adult vaccinations/immunizations for Meningitis, Measles, Mumps, and Rubella.

Immunizations for adults are NOT covered when services are required for or related to employment, education, marriage, adoption, insurance purposes, or when required by similar third parties.

This agreement does NOT cover vaccinations/immunization provided free of charge by the Department of Health or any other state or federal agency.

Pediatric Preventive Immunizations
Pediatric preventive immunizations are covered in accordance with current guidelines established by the American Academy of Pediatrics and are subject to change.

Coverage for immunizations includes the administration of the injection but not the biological agent. See the Summary of Benefits for benefit limits and level of coverage.

Related Exclusions
Immunizations for children are NOT covered when services are required for or related to employment, education, marriage, adoption, insurance purposes, or when required by similar third parties.

This agreement does NOT cover vaccinations/immunization provided free of charge by the Department of Health or any other state or federal agency.

Travel Immunizations
This agreement covers additional immunizations only when rendered before travel and only to the extent that such immunizations are recommended for adults and children by the Centers for Disease Control and Prevention (CDC), which are subject to change by the CDC.

3.31 Radiation Therapy/Chemotherapy Services

Medically necessary high dose chemotherapy and/or radiation services related to autologous bone marrow transplantation is limited. See definition of *Experimental/Investigational* – Section 7.0.

Inpatient
Radiation therapy and Chemotherapy services are covered as a *hospital service*. See Section 7.0 – definition of *hospital services*.

Outpatient
See the Summary of Benefits for benefit limits and level of coverage.

Radiation Therapy
We cover *hospital* and *doctor* services for *outpatient* radiation therapy. Radiation physics, dosimetry services, treatment devices, and *hospital services* are included in radiation treatment planning and therapy and are covered as part of our *allowance* for radiation therapy.

Chemotherapy Services
This agreement covers the *doctor's* administration fee and associated *hospital* supplies. For information regarding anti-neoplastic (chemotherapy) prescription drug coverage see Section 3.29 - Prescription Drugs.

In Your Home
See the Summary of Benefits for benefit limits and level of coverage.

Radiation Therapy
This agreement does NOT cover radiation treatment services received in your home.

Chemotherapy Services
This agreement covers the *doctor's* administration fee. For information regarding anti-neoplastic (chemotherapy) prescription drug coverage see Section 3.29 - Prescription Drugs.

In a Doctor's Office
See the Summary of Benefits for benefit limits and level of coverage.

Radiation Therapy
We cover *doctor* services for radiation therapy received in the *doctor's* office. Radiation physics, dosimetry services, and treatment devices are included in radiation treatment planning and therapy and are covered as part of our *allowance* for radiation therapy.

Chemotherapy Services
This agreement covers the *doctor's* administration fee. For information regarding anti-neoplastic (chemotherapy) prescription drug coverage see Section 3.29 - Prescription Drugs.

3.32 Respiratory Therapy

Inpatient
We cover *inpatient* respiratory therapy services as a *hospital service*. See Section 7.0 - definition of *hospital services*.

Outpatient/In a Doctor's Office
See the Summary of Benefits for benefit limits and level of coverage.

We cover *outpatient* respiratory therapy or respiratory therapy received in a *doctor's* office when your *doctor* orders the therapy under the following conditions:

- as part of a therapeutic *program* for up to fourteen (14) days before admitting you to the *hospital*; OR
- up to six (6) weeks after you have been discharged from the *hospital*.

In Your Home
Coverage is provided for durable medical equipment and oxygen at the same benefit limit and level of coverage as stated in the Summary of Benefits for medical equipment and medical supplies. See Section 3.23 - Medical Equipment, Medical Supplies, and Prosthetic Devices for coverage guidelines.

Related Exclusions
This agreement does NOT cover respiratory therapy services when received in your home unless received through a home care *program* or hospice care *program*. See Section 3.15 - Home Health Care and Section 3.16 – Hospice Care.

3.33 Skilled Care in a Nursing Facility

Care in a skilled nursing facility is covered if:

- your condition requires skilled nursing services, skilled rehabilitation services or skilled nursing observation;
- the services are required on a daily basis; AND
- this care can be provided ONLY in a skilled nursing facility.

Related Exclusions
This agreement does NOT cover custodial care, respite care, day care, or care in a facility that is not approved by us. See Section 5.6 - Services Provided by Facilities We Have Not Approved.

3.34 Smoking Cessation Programs

In accordance with Rhode Island General Law § 27-20-52, this agreement provides coverage for smoking cessation *programs*. Smoking cessation *programs* include, but are not limited to, the following:

- Smoking cessation counseling, such counseling must be provided by a physician or upon his or her referral by a qualified licensed practitioner.
- Over-the-counter or FDA approved nicotine replacement therapy when *medically necessary,* prescribed by a physician, and purchased at a *network pharmacy*.

This *program* requires you to attend counseling in conjunction with receiving a prescription for nicotine replacement therapy. See the Summary of Benefits for benefit limits and level of coverage.

Related Exclusions
This agreement does not provide coverage for nicotine replacement therapy without a prescription. This agreement does not cover nicotine replacement therapy when purchased from a *provider* other than a *network pharmacy*. This agreement does not cover nicotine replacement therapy when purchased from a mail order pharmacy. Prescribed smoking cessation drugs we have not approved are NOT covered under this agreement.

3.35 Speech Therapy

Speech therapy is the treatment of communication impairment and swallowing disorders. Speech therapy services facilitate the development of human communication and swallowing through assessment, diagnosis, and rehabilitation.

Inpatient
We cover *inpatient hospital* and skilled nursing facility speech therapy as a *hospital service*. See Section 7.0 - definition of *hospital services*.

Outpatient or in a Doctor's/Therapist's Office
We will cover speech therapy *rehabilitative services* when received from a registered therapist as part of a formal treatment plan for:

- speech or communication function loss;
- impairment as a result of an acute illness or injury; or
- an acute exacerbation of chronic disease.

Services must relate to performing basic functional communication or to assessing and/or treating swallowing dysfunction.

See Summary of Benefits for benefit limits and level of coverage.

Some services rendered by a speech therapist are classified as diagnostic tests. See Section 3.8 - Diagnostic Imaging, Lab, and Machine Tests and the Summary of Benefits for benefit limits and level of coverage for Diagnostic Imaging, Lab, and Machine Tests.

In Your Home
This agreement does NOT cover speech therapy services received in your home unless it is part of a home care *program*.

Related Exclusions
This agreement does NOT cover these services if another entity or agency is responsible for such services under state or federal laws which provide service for the health of school children or children with disabilities. (See generally, Title 16, Chapters 21, 24, 25 and 26 of the Rhode Island General Laws and applicable regulations governing health of school children and the special education of children with disabilities or comparable requirements established by federal law.)

This agreement does not cover *maintenance services.* This agreement does not cover *developmental services* including but not limited to, psychosocial speech delay, expressive language delay, behavioral problems, attention disorders, conceptual handicap, mental retardation, autism, or developmental delay. Educational classes and services for impairments that are self-correcting are not covered.

3.36 Surgery Services

General Surgery
If you have an operation to treat a disease or injury, we cover it as long as the following conditions apply:

- the operation is not *experimental/investigational* or cosmetic in nature;
- the operation is being performed at the appropriate place of service; AND
- the *doctor* is licensed to perform the surgery.

Kidney, Cornea, and Bone Marrow Transplants
Kidney, cornea, and bone marrow transplants are considered general surgery procedures for purposes of coverage under this agreement. *Medically necessary* high dose chemotherapy and/or radiation services related to autologous bone marrow transplantation is limited. See definition of *Experimental/Investigational* – Section 7.0.

Allogenic Bone Marrow transplant *covered health care services* include medical and surgical services for the matching participant donor and the recipient. Costs associated with donor searches are NOT covered. However, Human Leukocyte Antigen testing is covered as indicated in the Summary of Benefits, subject to certain conditions. For details see Section 3.19 - Human Leukocyte Antigen Testing.

To the extent that coverage for bone marrow or stem cell transplantation is more limited than the coverage required to be covered for "New Cancer Therapies," the applicable provisions of the Rhode Island Laws shall govern. See Section 7.0 for the definition of *experimental/investigational* services.

Multiple Surgeries
When a *doctor* performs more than one procedure in a day, there are rules that may reduce our *allowance* for the additional procedure. Our *allowance* may also include post-operative care and other procedures provided within specified time periods.

If More Than One Surgeon Operates
In addition to the type and purpose of surgery, our *allowance* differs depending on the number of surgeons involved, including assistant surgeons.

If two (2) surgeons perform separate operations during a single surgical session, each surgeon may submit a *claim* reporting the procedure performed and the circumstances involved. These *claims* will then be evaluated for payment on an individual basis.

Related Exclusions
This agreement does NOT cover the standby services of an assistant surgeon.

Mastectomy Services
This agreement provides coverage for a minimum of forty-eight (48) hours in a *hospital* following a mastectomy and a minimum of twenty-four (24) hours in a *hospital* following an axillary node dissection. Any decision to shorten these minimum coverages shall be made by the attending physician in consultation with and upon agreement with you. If you participate in an early discharge, defined as *inpatient* care following a mastectomy that is less than forty-eight (48) hours and *inpatient* care following an axillary node dissection that is less than twenty-four (24) hours, coverage shall include a minimum of one (1) home visit conducted by a physician or registered nurse.

This agreement provides benefits for mastectomy surgery and mastectomy-related services in accordance with the Women's Health and Cancer Rights Act of 1998 and Rhode Island General Law 27-20-29 et seq. For the *member* receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications at all stages of the mastectomy, including lymphedema.

Surgery to Treat Functional Deformity or Impairment
Reconstructive surgery and procedures which are performed to correct a functional deformity resulting from a previous therapeutic process or to correct a documented functional impairment caused by trauma, congenital anomaly or disease are covered benefits under this agreement. Functional indications for surgical correction do not include psychological, psychiatric or emotional reasons.

We cover some surgical procedures to treat functional impairments. We cover those procedures listed below to treat functional impairments when *medically necessary*:
- Abdominal wall surgery including Panniculectomy;
- Blepharoplasty and Ptosis Repair;
- Gastric Bypass or Gastric Banding;
- Nasal Reconstruction and Septorhinoplasty;
- Orthognathic surgery including Mandibular and Maxillary Osteotomy;
- Prophylactic Mastectomy;
- Reduction Mammoplasty;
- Removal of Breast Implants;
- Removal/Treatment of Proliferative Vascular Lesions and Hemangiomas;
- Removal/Treatment of Symptomatic Benign Skin Lesions; or
- Treatment of Varicose Veins.

Determinations for coverage for the procedures listed above may require review of medical documentation including history and physical, preoperative diagnostic studies, previously attempted conservative medical therapy and photographs, or other medical records.

In addition, we cover mastectomy-related services in accordance with the Women's Health and Cancer Rights Act of 1998 and Rhode Island General Law 27-20-29 et seq.

Related Exclusions
This agreement does NOT cover the above listed procedures when not *medically necessary.*

This agreement does NOT cover cosmetic procedures. Cosmetic procedures are performed primarily to refine or reshape body 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 are NOT covered. *Medically necessary* surgery performed at the same time as a cosmetic procedure is also NOT covered.

The following procedures are cosmetic procedures and are NOT covered under this agreement:
- Cervicoplasty;

- Chemical exfoliations, peels, abrasions (or dermabrasions or planing for acne, scarring, wrinkling, sun damage or other benign conditions);
- Correction of variations in normal anatomy including augmentation mammoplasty and correction of congenital breast asymmetry;
- Dermabrasion;
- Ear Piercing and/or repair of a torn earlobe;
- Excision of Excess Skin or Subcutaneous Tissue (except Panniculectomy as listed above);
- Genioplasty;
- Hair Transplants;
- Hair Removal (including electrolysis epilation);
- Surgery for Gynecomastia, including but not limited to mastectomy and reduction mammoplasty;
- Osteoplasty: Facial Bone Reduction;
- Otoplasty;
- 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;
- Subcutaneous Injection of Filling Material;
- Suction assisted Lipectomy; or
- Tattooing or Tattoo Removal.

This agreement provides benefits for mastectomy-related services in accordance with the Women's Health and Cancer Rights Act of 1998 and Rhode Island General Law 27-20-29 et seq.

Anesthesia Services
We cover *medically necessary* anesthesia services received from an anesthesiologist when the services are related to a covered procedure. Our *allowance* for the anesthesia service includes the anesthesia care during the procedure, time an anesthesiologist routinely spends with a patient in the recovery room, time spent preparing the patient for surgery, and for pre-operative consultations.

Our *allowance* for the surgical procedure includes local anesthesia.

Epidural anesthesia services administered at the base of the spine is covered only when administered during a covered obstetrical procedure.
Anesthesia administered by an anesthesiologist for electroconvulsive therapy is covered. See Section 3.2 - Behavioral Health Services - Mental Health Services.

Other than the pre-operative office visit, this agreement covers office visits and/or office consultations to anesthesiologists as an office visit. See Section 3.24 - Office Visits.

Anesthesia services when rendered at a *hospital* or *free-standing ambulatory surgi-center* in connection with a dental service are covered when the use of the *hospital* or *free-standing ambulatory surgi-center* is *medically necessary* and the setting in which the service received is determined to be appropriate. *Preauthorization* is recommended for this service. **The dental services will remain non-covered. See Section 5.17.**

Related Exclusions

This agreement does NOT cover local anesthesia provided by an anesthesiologist or anesthesia administered by a surgeon, assistant surgeon, or obstetrician. This agreement does NOT cover the services of a standby anesthesiologist. This agreement does NOT cover patient controlled analgesia, also known as pain management.

3.37 Vision Care Services

Eye Examinations

We cover one routine eye exam per *calendar year* if an optometrist or ophthalmologist performs the examination. We cover *medically necessary* eye examinations. See the Summary of Benefits for benefit limits and level of coverage.

4.0 HOW WE PAY FOR YOUR COVERED HEALTH CARE SERVICES

Payments we make to you are personal and you cannot transfer or assign any of your right to receive payments under this agreement to another person or organization.

4.1 How We Pay Network Providers

We pay *network providers* directly for *covered health care services*. You are responsible for *copayments* and/or *deductibles*, if any, which may apply to a *covered health care service*. *Network providers* agree not to bill, charge, collect a deposit from, or in any way, seek reimbursement from you for a *covered health care service*, except for the *copayments*, *deductibles,* and/or the difference between the *maximum benefit* and our *allowance*, if any, which may apply to a *covered health care service.*

Not all of the individual *providers* at a *network* facility will be *network providers*. It is your responsibility to verify that each *provider* from whom you receive care is in the *network*. However, if you receive certain types of services at a *network* facility, and there are *covered health care services* provided attendant to those services by a *non-network provider* outside of your control, you will be reimbursed for such *covered health care services* based upon our *allowance* at the *network* level of benefits. The types of services this provision applies to are:

- *inpatient* admissions at a *network* facility under the direction of a *network* physician;
- *outpatient* services performed at a *network* facility by a *network* physician; AND
- emergency room services at a *network* facility.

4.2 How We Pay Non-Network Providers

You are responsible for paying all *charges* from a *non-network provider.* We reimburse you up to the *maximum benefit* or our *allowance*, less any *copayments* and/or *deductibles* which may apply to a *covered health care service* or procedure. We reimburse you for *non-network provider* services according to the same guidelines we use to pay *network providers*. Our reimbursement for *non-network provider* services will never be more than the amount we pay for *network provider* services. Benefits may not be assigned, unless the Rhode Island General Law § 27-20-49 (Dental Insurance assignment of benefits) applies.

4.3 Coverage for Services Provided Outside of the Service Area (BlueCard)

You may receive *covered health care services* when you are outside of the geographic area that we service. When you do so, your services will be covered as if you received services from a *network provider* if the servicing *provider* participates with the local Blue Cross and Blue Shield *plan* where the services were provided. You are responsible for *copayments*, *deductibles,* and/or the difference between the *maximum benefit* and the negotiated price, if any. This use of another Blue Cross and Blue Shield regional network is made available through a program called *BlueCard*.

When you obtain health care services through *BlueCard* outside the geographic area we serve, the amount you pay for *covered health care services* is calculated on the lower of:

- The billed *charges* for your *covered health care services*, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield *plan* (“Host Blue”) passes on to us.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. However, sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-

claims transactions with your health care *provider* or with a specified group of *providers*. The negotiated price may also be billed *charges* reduced to reflect an average expected savings with your health care *provider* or with a specified group of *providers.* The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for *covered health care services* that does not reflect the entire savings realized, or expected to be realized, on a particular *claim* or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual *BlueCard* method noted above in this section or require a surcharge, we would then calculate your liability for any *covered health care services* in accordance with the applicable state statute in effect at the time you received your care.

Because of the many different arrangements between state Blue Cross and Blue Shield *plans* and their participating facilities and *providers* as well as different statutory requirements, it is not possible to set forth in this agreement specific information for each out-of-area facility and *provider*. However, if you contact our Customer Service Department at (401) 459-5000 or 1-800-639-2227 prior to utilizing out-of-area services, we may be able to provide you with information regarding specific facilities and *providers*.

5.0 HEALTH CARE SERVICES NOT COVERED UNDER THIS AGREEMENT

This agreement does NOT cover health care services which:

- have not been assigned a CPT or other code;
- have not been finally approved by the FDA or other governing body;
- we have not reviewed; or
- we have not determined are eligible for coverage.

This agreement does not provide coverage for all health care services which:

- have been assigned a CPT code;
- have been finally approved by the FDA or other governing body; or
- we have reviewed.

If a service or category of service is not listed as covered, it is not covered under this agreement.

This section lists many of the services or categories of services that are non-covered (excluded). In addition to this section see Section 3.0 for *Covered Health Care Services* and their related exclusions; AND Section 1.0 and Section 3.0 for more information about how we identify *new services* and review and make coverage determinations.

5.1 Services Not Medically Necessary

This agreement does NOT cover *hospital* care (admission tests, services, supplies, or continued care), medical care, rehabilitation, or any other treatment, procedure, facility, equipment, drug, device, supply or service which we determine is NOT *medically necessary*. (See Section 7.0 - Glossary). We have the right and discretionary authority to use any reasonable means to determine the medical necessity of this care and we may examine *hospital* records, reports and *hospital utilization review* committee statements.

We have the right to deny payments if a *doctor* or *hospital* does not supply medical records required to determine medical necessity. We also have the right to deny or reduce payment if the records supplied do not provide adequate justification for performing the service.

If the *hospital* performs routine screenings or tests which are not *medically necessary* for the diagnosis or treatment of your condition or which are not specifically ordered by the *doctor* who admits you, this agreement does NOT cover them.

5.2 Services Not Listed in Section 3.0

This agreement only covers services listed under Section 3.0 - *Covered Health Care Services.* This agreement does NOT cover services that may in and of themselves otherwise be considered covered, when provided attendant to a non-covered course of service or as a component of a non-covered regimen of care.

5.3 Services Covered by the Government

This agreement does NOT cover medical expenses for any condition, illness or disease which should be covered by the United States government or any of its agencies, Medicare, any state or municipal government or any of its agencies (except *emergency* care when there is a legal responsibility to provide it). This agreement does NOT cover services for military-related

conditions and services or supplies required as a result of war, declared or undeclared, or any military action which takes place after your coverage becomes effective.

5.4 Services and Supplies Mandated by Laws in Other States

Any *charges* for services and supplies which are required under the laws of a state other than the Rhode Island Law and which are not provided under this agreement are NOT covered.

5.5 Services Provided By College/School Health Facilities

This agreement does NOT cover health care services received in a facility primarily designed to care for students, faculty, or employees of a college or other institution of learning.

5.6 Services Provided By Facilities We Have Not Approved

This agreement does NOT cover custodial care, rest care, day care, or non-skilled care in any facility. This agreement does NOT cover care in convalescent/nursing homes, homes for the aged, halfway houses, or other residential facilities. This agreement does NOT cover *hospital services* which are not performed in a *hospital* defined in Section 7.0 - Glossary.

5.7 Services Performed by Excluded Providers

This agreement does NOT cover health care services performed by a *provider w*ho 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 (www.oig.hhs.gov/fraud/exclusions/listofexcluded.html) or the Excluded Parties List System website maintained by the U.S. General Services Administration (www.epls.gov).

5.8 Services Performed by People/Facilities Who Are Not Legally Qualified or Licensed

This agreement does NOT cover health care services performed in a facility or by a physician, surgeon or other person who is not legally qualified or licensed according to relevant sections of Rhode Island Law, or other governing bodies or who does not meet our credentialing requirements.

5.9 Services If You Leave the Hospital or If You Are Discharged Late

If you leave the *hospital* for a day or portion of a day, this agreement does NOT cover any *hospital services* for that day (unless you are leaving to receive treatment somewhere else or through a Blue Cross & Blue Shield of Rhode Island approved *program*). This agreement does NOT cover any *hospital charges* you accumulate when you are discharged from the *hospital* later than the usual discharge time.

5.10 Benefits Available from Other Sources

This agreement does NOT cover the portion of costs for health care services you receive when there is no charge to you or would have been no charge to you absent this agreement. This agreement does NOT cover health care services when you can recover all or a portion of the cost of such services through a federal, state, county, or municipal law or through legal action. This is true even if you choose not to assert your rights under these laws or if you fail to assert your rights under these laws.

5.11 Blood Services

This agreement does NOT cover *charges* for whole blood, red blood cells, blood replacement and penalty fees. This agreement does NOT cover any services related to drawing, processing, or storage of your own blood.

5.12 Charges for Administrative Services

This agreement does NOT cover *charges* for missed appointments, *charges* for completion of *claim* forms or other administrative *charges*.

5.13 Christian Scientist Practitioners

This agreement does NOT cover the services of Christian Scientist Practitioners.

5.14 Clerical Errors

If a clerical error or other mistake occurs, that error shall not deprive you of coverage under this agreement. A clerical error also does not create a right to benefits.

5.15 Consultations -Telephone

This agreement does NOT cover telephone consultations.

5.16 Deductibles and Copayments

This agreement does NOT cover *deductibles* or *copayments*, if any.

5.17 Dental Services

This agreement does NOT cover:

- general dental services such as extractions (including full mouth extractions), prostheses, braces, operative restorations, fillings, medical or surgical treatment of dental caries, gingivitis, impactions, periodontal surgery, non-surgical treatment of temporomandibular joint dysfunctions, including appliances or restorations necessary to increase vertical dimensions or to restore the occlusion, panorex X-rays or dental X-rays;
- dental appliances/devices;
- *hospital services*, *free-standing ambulatory surgi-center* services, and anesthesia services provided in connection with a dental service when we determine the use of the *hospital* or *free-standing ambulatory surgi-center* or the setting in which the services are received is determined to be not *medically necessary*.

This agreement does NOT cover any preparation of the mouth for dentures and/or dental or oral surgeries such as, but not limited to:

- apicoectomy, per tooth, first root;
- alveolectomy including curettage of osteitis or sequestrectomy;
- alveoplasty, each quadrant.
- complete surgical removal of inaccessible impacted mandibular tooth mesial surface;
- excision of feberous tuberosities;
- excision of hyperplastic alveolar mucosa, each quadrant;
- operculectomy excision periocoronal tissues;
- removal of partially bony impacted tooth;
- removal of completely bony impacted tooth, with or without unusual surgical complications;

- surgical removal of partial bony impaction;
- surgical removal of impacted maxillary tooth;
- surgical removal of residual tooth roots; or
- vestibuloplasty with skin/mucosal graft and lowering the floor of the mouth.

5.18 Determination of Post-Operative Fluid or Electrolyte Balance

Procedures to determine post-operative fluid or electrolyte balance are NOT covered.

5.19 Employment–Related Injuries

This agreement does NOT cover health care services when performed to treat work-related illnesses, conditions, or injuries whether or not you are covered by Workers' Compensation law, unless; you are (1) self-employed, a sole stockholder of a corporation, or a member of a partnership; and (2) such work-related illnesses, conditions, or injuries were incurred in the course of your self-employment, sole stockholder, or partnership activities; and (3) you are not enrolled as an employee under a group health *plan* sponsored by an employer other than the business or partnership described above.

5.20 Eye Exercises

Eye exercises and visual training services are NOT covered.

5.21 Eyeglasses and Contact Lenses

Eyeglasses and contact lenses are NOT covered unless they are necessary as prosthetic devices after a cataract operation or a cornea transplant.

5.22 Freezing and Storage of Blood, Sperm, Gametes, Embryo and Other Specimens

This agreement does NOT cover freezing and storage of blood, gametes, sperm, embryos, or other tissues for future use. This agreement does NOT cover any services related to drawing processing or storage of your own blood.

5.23 Gene Therapy, Genetic Screening, and Parentage Testing

This agreement does NOT cover gene therapy, genetic screening, or parentage testing.

5.24 Illegal Drugs and Chronic Addiction

Drugs which are dispensed in violation of state or federal law are NOT covered.
Methadone or other drug maintenance treatments are NOT covered.

5.25 Infant Formula

This agreement does NOT cover infant formula whether or not prescribed.

5.26 Marital Counseling

This agreement does NOT cover marital counseling or training services.

5.27 Personal Appearance and/or Service Items

Services and supplies for your personal appearance and/or comfort whether or not prescribed by a *doctor* and regardless of your condition are NOT covered, such as, but not limited to, a radio, telephone, television, air conditioner, humidifier, air purifier, beauty and barber services. Travel expenses, whether or not prescribed by a *doctor*, are NOT covered. This agreement does NOT cover items whose typical function is not medical such as, but not limited to, recliner lifts, air conditioners, humidifiers, or dehumidifiers. This agreement does NOT cover items that

do not meet the durable medical equipment, medical supplies, and prosthetic devices minimum specifications such as, but not limited to standers, raised toilet seats, and cribs.

5.28 Private Duty Nursing Service

This agreement does NOT cover private duty nursing services.

5.29 Psychoanalysis for Educational Purposes

Psychoanalysis services are NOT covered regardless of symptoms you may have. Psychotherapy services you receive which are credited towards a degree or to further your education or training, regardless of symptoms that you may have, are NOT covered.

5.30 Research Studies

This agreement does NOT cover research studies.

5.31 Reversal of Voluntary Sterilization

This agreement does NOT cover the reversal of voluntary sterilization or infertility treatment for an individual that previously had a voluntary sterilization procedure.

5.32 Services Provided By Relatives or Members of Your Household

This agreement does NOT cover *charges* for any services provided by a person who is a member of your household or the cost of any care provided by one of your relatives (by blood, marriage, or adoption).

5.33 Sex Transformations and Dysfunctions

Health care services related to sex transformations are NOT covered. Health care services related to sexual dysfunctions or inadequacies, except services approved by us and necessary for the treatment of a condition arising out of organic dysfunctions, are NOT covered. (i.e., Therapeutic services will be covered when the cause of the dysfunction is physiological, not psychological.) This agreement does NOT cover Viagra or any therapeutic equivalents.

5.34 Supervision of Maintenance Therapy

This agreement does NOT cover the supervision of maintenance therapy for chronic disease which is not aggravated by surgery and would not ordinarily require hospitalization. This agreement does NOT cover rehabilitation for maintenance purposes.

5.35 Surrogate Parenting

This agreement does NOT cover any services related to surrogate parenting. This agreement does NOT cover the newborn child of a surrogate parent.

5.36 Therapies, Acupuncture and Acupuncturist Services, and Biofeedback

This agreement does NOT cover recreational therapy, massage therapy, aqua therapy, maintenance therapy, and aromatherapy. Therapies, procedures, and services for the purpose of relieving stress are NOT covered. This agreement does NOT cover acupuncture and acupuncturist services, including X-ray and laboratory services ordered by an acupuncturist. Pelvic floor electrical stimulation, pelvic floor magnetic stimulation, biofeedback training, pelvic floor exercise, and any other exercise therapy are NOT covered. This agreement does NOT cover biofeedback by any modality for any condition.

5.37 Weight Loss Programs

This agreement does NOT cover health care services, including drugs, related to *programs* designed for the purpose of weight loss, such as, but not limited to, commercial diet plans, weight loss *programs*, and any services in connection with such plans or *programs*.

6.0 HOW TO FILE AND APPEAL A CLAIM

6.1 How to File a Claim

You must file all *claims* within one *calendar year* of the date you receive a *covered health care service*. *Member* submitted *claims* that arrive after this deadline are invalid unless:

- we determine that it was not reasonably possible for you to file your *claim* prior to the filing deadline; AND
- you file your *claim* as soon as possible but no later than ninety (90) calendar days after the filing deadline elapses (unless you are legally incapable).

Our payments to you or the *provider* fulfill our responsibility under this agreement. Your benefits are personal to you and cannot be assigned, in whole or in part, to another person or organization.

Network providers file *claims* for you and must do so within one hundred and eighty (180) days of providing a *covered health care service* to you.

Non-network providers may or may not file *claims* for you. If the *non-network provider* does not file the *claim* on your behalf, you will need to file the *claim* yourself. To file a *claim*, please send us an itemized bill including the following:

- patient's name;
- your *member* identification 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 mail the *claim* to:

Blue Cross & Blue Shield of Rhode Island
Attention: Claims Department
444 Westminster Street
Providence, RI 02903

6.2 Complaint and Administrative Appeal Procedures

A **Complaint** is a verbal or written expression of dissatisfaction with any aspect of our operation or the quality of care you received. A *complaint* is not an appeal, an inquiry, or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to your satisfaction.

An **Administrative Appeal** is a verbal or written request for us to reconsider a full or partial denial of payment for services that were denied because we determined that the services were excluded from coverage or because you or your *provider* did not follow Blue Cross & Blue Shield of Rhode Island's requirements.

How to File a Complaint or Administrative Appeal

If your inquiry is not resolved to your satisfaction, you may file a *complaint* or an *administrative appeal*. If you wish to file a *complaint* or *administrative appeal*, you must do so within one hundred and eighty (180) calendar days from the date of notice of the *claim* determination. You can do so by calling our Customer Service Department at (401) 459-5000 or 1-800-639-

2227. The Customer Service Representative will log your call and the nature of the issue and attempt to resolve the problem.

You may also file a *complaint* or *administrative appeal* in writing. To file a *complaint* or *administrative appeal*, you must provide the details of your *complaint* or *administrative appeal* and include the following information:

- name, address, *member* ID number;
- summary of the *complaint* or *administrative appeal*, any previous contact with Blue Cross & Blue Shield of Rhode Island and a brief description of the relief or solution you are seeking;
- any additional information such as referral forms, *claims* or any other documentation that you would like us to review;
- the date of incident or service; and
- your signature.

You can use the *member Complaint/Administrative appeal* form or you can send us a letter with the information requested above. A Customer Service Representative can provide you with a *Complaint/Administrative appeal* form upon request. If someone is filing a *complaint* or *administrative appeal* on your behalf, you must send us a notice that the person has the authority to receive information from us on your behalf. You must sign this notice.

Please mail the *complaint, administrative appeal*, or notice to:

Blue Cross & Blue Shield of Rhode Island
Attention: Grievance and Appeals Unit
444 Westminster Street
Providence, Rhode Island 02903

You will receive an acknowledgement letter from us within ten (10) business days of the receipt of your written *complaint* or *administrative appeal*. Most verbal *complaints* are acknowledged by the Customer Service Representative when you make your *complaint* and you will not receive an acknowledgement letter. The Grievance and Appeals Unit will conduct a thorough review of your *Complaint* or *Administrative appeal*. In most cases, the combined time from our receipt of your *Complaint* or *Administrative appeal* and sending a written decision to you will not exceed sixty (60) calendar days. Your determination letter from us will provide you with information regarding our determination (decision).

Blue Cross & Blue Shield of Rhode Island does not offer any further internal or external review, though you may notify the State of Rhode Island Department of Health regarding your concerns or refer to the section for Judicial Review information.

6.3 Medical Appeal Procedures

A ***medical appeal*** is a verbal or written request for us to reconsider a full or partial denial of payment for services that were denied because we determined one of the following:

- The services were not *medically necessary*; or
- The services are *experimental* or *investigational*.

If we deny payment for a service for medical reasons, you will receive the denial in writing. The written denial you receive from us will explain the reason for the denial and provide specific instructions for filing a *medical appeal*. Written *medical appeals* should be sent to:

Blue Cross & Blue Shield of Rhode Island
Attention: Grievance and Appeals Unit
444 Westminster Street
Providence, Rhode Island 02903

You are entitled to the following levels of review when seeking a *medical appeal*.

Level 1 Review
You may request a Level 1 review of any matter subject to *medical appeal* by making a request for such review to us within one hundred and eighty (180) calendar days of the initial determination letter. You may request this review by calling our Customer Service Department, but we strongly suggest that you submit your request in writing to ensure your request is accurately reflected.

You will receive notification of the determination on a Level 1 review within fifteen (15) calendar days of receipt of the appeal request. If you are requesting reconsideration (Level 1 review) of a service that was denied after you already obtained the service (retrospectively), then you will receive written notification of our determination within thirty (30) calendar days of our receipt of the appeal.

Level 2 Review
You may request a Level 2 appeal review (preferably in writing) if our denial was upheld during the Level 1 review process. Your Level 2 appeal review will be reviewed by a *provider* in the same specialty as your treating *provider*. You must submit your request for a Level 2 appeal review within one hundred and eighty (180) calendar days of the date of the Level 1 determination letter. Upon request for a Level 2 review, we will provide you with the opportunity to inspect the medical file and add information to the file. You will receive written notification of a determination on a Level 2 review within fifteen (15) calendar days of receipt of the appeal request. If the service you are requesting review of was denied after you already obtained the service (retrospectively), you will receive written notification of our determination within thirty (30) calendar days of receipt of the appeal request.

Note*: You may request an expedited review of denied services if the circumstances are an emergency or if you are in an inpatient setting. Due to the urgent nature of an expedited Medical Appeal, to request an expedited Medical Appeal you or your physician or provider must call the Grievance and Appeals Department at 1-800-528-4141. An expedited determination will be made within two (2) business days following receipt of all medical documentation required to conduct the review, but not to exceed seventy-two (72) hours from the receipt of the appeal.*

External Appeal
You may request an external review by an outside review agency. A fee will be associated with this request. For *members* covered by group health *plans*, this External Appeal is a voluntary level of appeal. This means you may choose to participate in this level of appeal, or you may file suit in an appropriate court of law (See Judicial Review). To request an external

review you must submit your request in writing to us within one hundred and eighty (180) calendar days of your receipt of the medical appeal denial notification.

If you are appealing a service that was denied because we determined that the service was not *medically necessary*, you will select the external appeal agency that will perform the external appeal from a list of Department of Health-approved agencies. You will be responsible for fifty percent (50%) of the *charges* and fees from the external agency and we will pay the remaining fifty percent (50%). However, if the external appeal agency overturns our denial determination, we will reimburse you for your half of the cost of the review.

For all non-*emergency* appeals, the external appeal agency will notify you of its determination within ten (10) business days of the agency's receipt of the information. For all *emergency* external appeals, the external appeals agency will notify you of its determination within two (2) business days but not to exceed seventy-two (72) hours from the agency's receipt of the appeal.

Judicial Review
If you are dissatisfied with the final decision of the external appeal agency, you are entitled to a final review (a Judicial Review). This review will take place in an appropriate court of law.

Note: Once a member or provider receives a decision at one of the several levels of appeal (Level 1, Level 2, External, and Judicial), the provider or the member may not ask for an appeal at the same level again, unless additional information that could impact such decisions can be provided.

6.4 Grievances Unrelated to Claims

We encourage you to discuss any *complaint* that you may have about any aspect of your medical treatment with the health care *provider* that furnished the care. In most cases, issues can be more easily resolved when they are raised when they occur. If, however, you remain dissatisfied or prefer not to take up the issue with your *provider*, you may access our *complaint* and grievance procedures.

You may also access our *complaint* and grievance procedures if you have a *complaint* about our service or regarding one of our employees. In order to initiate a grievance, please call our Customer Service Department at (401) 459-5000 or 1-800-639-2227. The Customer Service Department will log in your call and begin working towards the resolution of your *complaint*.

The grievance procedures described in this Section 6.4 do not apply to medical necessity determinations (addressed in Section 6.3), *complaints* regarding payments (addressed in Section 6.2), *claims* of medical malpractice or to allegations that we are liable for the professional negligence of any *doctor*, *hospital*, health care facility or other health care *provider* furnishing services under this agreement.

6.5 Legal Action

You cannot recover payment for a *claim* through legal actions unless you notify us in writing that you intend to take action against us.

You may not begin court proceedings prior to the expiration of sixty (60) days after the date you filed your *claim*. In no event may legal action be taken against us later than three (3) years from the date you were required to file the *claim*. See Section 6.1-How to File a Claim.

6.6 Our Right To Withhold Payments

We have the right to withhold payment during the period of investigation on any *claim* we receive that we have reason to believe might not be eligible for coverage. We will also conduct pre-payment review on a *claim* we have reason to believe has been submitted for a service not covered under this agreement. We will make a final decision on these *claims* within sixty (60) days after the date you filed said *claim*.

We also have the right to perform post-payment reviews of *claims*. If we determine misrepresentation was used when you filed the *claim*, or if we determine that a *claim* should not have been paid for any reason, we may take all necessary steps (including legal action) to recover funds paid to you or to a *provider*.

6.7 Subrogation

In the event that any benefit is provided for, or any payment is made or credit extended, to a *subscriber* under this agreement, Blue Cross & Blue Shield of Rhode Island shall be subrogated and shall succeed to the *subscriber's* right of recovery against any party, including such individual's employer/agent, alleged to be legally responsible for the *subscriber*. This right of *subrogation* extends to uninsured and underinsured motorist clauses and no-fault insurance policies. This Section 6.7 does not affect the order of determination of benefits under any applicable Coordination of Benefits provision.

The *subscriber* acknowledges that Blue Cross & Blue Shield of Rhode Island's *subrogation* rights shall be considered as a first priority *claim* against any party to be paid before any other *claims*, including *claims* for compensatory and/or punitive damages by the *subscriber*. The *subscriber* shall take such action, furnish such information and assistance, and execute such assignments and other instruments as we may require to facilitate enforcement of our rights hereunder, and shall take no action prejudicing the rights and interests of Blue Cross & Blue Shield of Rhode Island. We may take such action as may be necessary and appropriate to preserve our rights under this *subrogation* provision. We may collect, at our option, any and all amounts from the proceeds of any settlement of judgment that may be recovered by such *subscriber*, or such *subscriber's* legal representative. Any proceeds of settlement or judgment shall be held in trust by the *subscriber* for our benefit under this *subrogation* provision, and we shall be entitled to recover reasonable attorneys' fees from such *subscriber* incurred in collecting proceeds from such individual. In the event that there is a court-ordered distribution of funds, we must be notified as soon as possible and given a reasonable time to respond before such distribution takes place. Our *subrogation* rights under this Section 6.7 are enforceable to the extent permitted by Rhode Island Law.

7.0 GLOSSARY

ALLOWANCE is the maximum amount, as determined by us, to be acceptable for a *covered health care service*. Our *allowance* for a *covered health care service* may include payment for other related services. See Section 4.0 - How We Pay For Your Covered Health Care Services and the Summary of Benefits for services subject to *copayments, deductibles,* and/or *maximum benefits.*

When you receive *covered health care services* from a *network provider*, the *provider* has agreed to accept our *allowance* as payment in full. You will be responsible to pay your *copayments*, *deductibles*, and/or the difference between the *maximum benefit* and our *allowance*, if any.

When you receive *covered health care services* from a *non-network provider*, you will be responsible for the *provider's charge.* Our reimbursement will be based on the lesser of our *allowance,* the *non-network provider's charge,* or the *maximum benefit,* less any *copayments* and/or *deductibles.*

BEHAVIORAL HEALTH CASE MANAGER means the individual or entity that has the responsibility to preauthorize and manage the provision of covered behavioral health care services including those services provided under the *chemical dependency* benefit.

BENEFITS means any treatment, facility, equipment, drug, device, supply or service for which you receive reimbursement under a *plan*.

BLUECARD is a national program in which all Blue Cross and Blue Shield plans participate that benefits *subscribers* who receive *covered health care services* outside their own plan's service area. See Section 4.3 for details.

CALENDAR YEAR means a 12-month period beginning on January 1st and ending December 31st.

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

CHEMICAL DEPENDENCY means the chronic abuse of alcohol or other drugs characterized by impaired functioning, debilitating physical condition, the inability to keep from or reduce consuming the substance, or the need for daily use of the chemical in order to function. The term "chemical" includes alcohol and addictive drugs, but not caffeine or tobacco.

CHEMICAL DEPENDENCY TREATMENT FACILITY means a *hospital* or facility which is licensed by the Rhode Island Department of Health as a *hospital* or as a community residential facility for *chemical dependency* and *chemical dependency* treatment, unless we can establish through a pre-admission certification process that services are not available at a facility that meets these requirements.

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

COBRA means the Consolidated Omnibus Budget Reconciliation Act passed by Congress in 1986. This law provides continuation of group health *plan* coverage that would otherwise be terminated. *COBRA* gives certain former employees, retirees, spouses, and dependents the right to temporary continuation of health coverage at group rates.

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

COVERED HEALTH CARE SERVICES means any service, treatment, procedure, facility, equipment, drug, device, or supply which we have reviewed and determined is eligible for reimbursement under this agreement.

DEDUCTIBLE means the amount that you must pay each *calendar year* before we begin to pay for certain *covered health care services*.. The *deductible* applies to all *covered health care services*, with the exception of *preventive care services*.

The *network provider* and *non-network provider calendar year deductibles* accumulate separately. The *deductible* amount applied to a covered health care expense is based on the lower of our *allowance* or the *provider's charge*.

The family *calendar year deductible* is met by collectively adding the amount of covered health care expenses applied to the *deductible* for all eligible family *members*.

See the Summary of Benefits for your *calendar year deductible* amount(s).

DEVELOPMENTAL SERVICES means therapies, typically provided by a qualified professional using a treatment plan, that are intended to diminish deficiencies in normal age appropriate function. They are directed at limiting deficiencies related to injury or disease that typically has been present since birth (even if not realized until a later developmental stage), but may be the result of injury disease in the developmental period. *Developmental services* are applied for sustained periods of time to promote acceleration in developmentally related functional capacity. This agreement does not cover *developmental services* unless specifically listed as covered.

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

ELIGIBLE PERSON Please see Section 2.1 for a detailed description of who is eligible to enroll as a dependent under this agreement.

EMERGENCY means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: serious jeopardy to the health of an individual (or, with respect to a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

EXPERIMENTAL/INVESTIGATIONAL means any health care service that has progressed to limited human application, but has not been recognized as proven and effective in clinical medicine. See Section 3.12 for a more detailed description of the type of health care services we consider *experimental/investigational*.

FREE-STANDING AMBULATORY SURGI-CENTER means a state licensed facility which is equipped to surgically treat patients on an *outpatient* basis.

HEALTH SAVINGS ACCOUNT (HSA) is a tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an *HSA*, is covered under a *high deductible health plan*.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) is a health *plan* that satisfies certain requirements with respect to *deductibles* and *out-of-pocket expenses*. The *plan* cannot provide payment for any *covered health care service* until the *calendar year deductible* is satisfied, with the exception of *preventive care services*.

HOSPITAL means any facility worldwide that provides medical and surgical care for patients who have acute illnesses or injuries AND is either listed as a *hospital* by the American Hospital Association (AHA) OR accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). "*Hospital"* does not refer to convalescent homes, rest homes, nursing homes, homes for the aged, school/college infirmaries, halfway houses or residential facilities, long-term care facilities, *urgent care centers* or *free-standing ambulatory surgi-centers*, facilities providing primarily custodial, educational or rehabilitative care, or sections of *hospitals* used for those purposes, even if accredited by the JCAHO or listed in the AHA directory.

- **A GENERAL HOSPITAL** means a *hospital* which is designed to care for medical and surgical patients with acute illness or injury.

- **A SPECIALTY HOSPITAL** means a *hospital* or the specialty unit of *a general hospital* which is licensed by the State and designed to care for patients with injuries or special illnesses, including but not limited to, an acute mental health or acute short-term rehabilitation unit or *hospital*.

HOSPITAL SERVICES are the following in-*hospital services*:
- anesthesia supplies;
- blood services including: administration, typing, crossmatching, drawing, maintenance of donor room, and *charges* for plasma and derivatives. *Charges* for whole blood, red blood cells and blood replacement costs and penalty fees are NOT covered;
- cardiac pacemakers;
- computerized axial tomography (CAT or CT scan) and magnetic resonance imaging (MRI);
- diagnostic imaging, radiation therapy and diagnostic and therapeutic radioisotopic services;
- drugs and medications as currently listed in the National Formulary or the U.S. Pharmacopoeia;
- electrocardiograms (EKGs) and electroencephalogram (EEG);

- general and specialty nursing care;
- hearing evaluation;
- hemodialysis - use of machine and other physical equipment;
- inhalation and oxygen, respiratory therapy, and ventilator support;
- insulin and electroconvulsive therapy;
- laboratory and pathology testing and pulmonary function tests;
- mammogram;
- meals and other dietary services;
- medical and surgical supplies;
- occupational therapy;
- original prosthetic and initial prosthesis when provided and billed for by the *hospital* where you are an *inpatient* or the *hospital* where you return within a reasonable period of time for an initial prosthesis or original prosthetic, providing the prosthesis or the prosthetic is related to the original *hospital* stay;
- pap smear;
- physical therapy;
- recovery room;
- *rehabilitation services*;
- room accommodations in a ward or *semi-private room*;
- services performed in intensive care units;
- services of a licensed clinical psychologist when ordered by a *doctor* and billed by a *hospital*;
- speech evaluation and therapy;
- ultrasonography (ultrasounds);
- use of the operating room for surgery, anesthesia, and recovery room services; and
- other *hospital services* necessary for your treatment which we have approved.

INPATIENT is a patient admitted, at least overnight, to a *hospital* or other health care facility.

LEGEND DRUG is a drug that federal law prohibits the dispensing of without a prescription.

MAINTENANCE SERVICES means any service that is intended to maintain current function, retard, or prevent decline in function. *Maintenance services* are typically long -term therapies that do not apply to individuals with an acute chronic illness or functional deficit. See exclusion 5.34 Supervision of Maintenance Therapy and Maintenance Services.

MAXIMUM BENEFIT means the total benefit allowed under this *plan* for *covered health care services* associated with a particular condition or service.

When you receive *covered health care services* from a *network provider*, the *provider* has agreed to accept our *allowance* as payment in full. You will be responsible to pay the difference between the *maximum benefit* and our *allowance,* and any applicable *copayments* and/or *deductibles.*

When you receive *covered health care services* from a *non-network provider*, you will be responsible for the *provider's charge.* Our reimbursement will be based on the lesser of our *allowance,* the *non-network provider's charge,* or the *maximum benefit,* less any *copayments* and/or *deductibles*.

MAXIMUM OUT-OF-POCKET EXPENSE means the total amount of *deductible* and *copayments* that you must pay each *calendar year* for *covered health care services* provided by *network* and *non-network hospitals*, facilities, *doctors,* and other health care *providers.*

The family *calendar year maximum out-of-pocket expenses* is met by collectively adding the *deductible* and *copayment* amount applied to covered health care expenses for all eligible family *members*.

We will pay up to 100% of our *allowance* for the remainder of the *calendar year* once you have met the *maximum out-of-pocket expense*.

See the Summary of Benefits for your *maximum out-of-pocket expenses.*

MEDICALLY NECESSARY means that the health care services provided to treat your illness or injury, as determined by Blue Cross & Blue Shield of Rhode Island are:

- necessary for the diagnosis, treatment, or care of the condition, disease ailment or injury for which it is prescribed or performed;
- appropriate with regard to standards of medical practice within the medical community;
- not primarily for the convenience of the *member*, the *member's* family or *provider* of such *member;* AND
- the most appropriate supplies or level of service which can safely be provided to the *member*, i.e. no less expensive professionally acceptable alternative is available.

We have the right and discretionary authority to determine whether a health care service is *medically necessary*, and any such determination made by us in good faith is binding upon you.

We determine medical necessity on a case-by-case basis. THE FACT THAT YOUR *DOCTOR* PERFORMED OR PRESCRIBED A PROCEDURE DOES NOT MEAN THAT IT IS *MEDICALLY NECESSARY*. We determine medical necessity solely for purposes of *claims* payment under this agreement.

NETWORK PROVIDER (NETWORK) is a *provider* that has entered into an agreement with us or a Blue Cross or Blue Shield *plan* of another State.

NEW SERVICE means a service we have not previously reviewed to determine whether the service is eligible for coverage under this agreement.

NON-NETWORK PROVIDER (NON-NETWORK) is a *provider* that has not entered into an agreement with us or another Blue Cross or Blue Shield *plan* of another State.

OUTPATIENT is a patient receiving ambulatory care at a *hospital* or other health care facility without being admitted overnight.

PLAN means any *hospital* or medical service *plan* or health insurance benefit package provided by an organization. This includes an organization that is a *member* of the Blue Cross and Blue Shield Association and Blue Cross & Blue Shield of Rhode Island as well as:

(a) group insurance or group-type coverage, whether insured or self-insured, including group-type coverage through an HMO, other prepayment group practice or individual practice *plan*; AND
(b) coverage under a governmental *plan* or coverage required to be provided by law. This does not include a state *plan* under Medicaid (Title XIX, Grant to States for Medical Assistance Programs, of the U.S. Social Security Act as amended from time to time).

PLAN LIFETIME MAXIMUM means the total amount that we will pay for *covered health care services* per *subscriber* under this agreement. See the Summary of Benefits for your *plan lifetime maximum*.

PREAUTHORIZATION is a process that determines if a health care service qualifies for benefit payment. *Preauthorization* is not a guarantee of payment, as the process does not take benefit limits into account.

Preauthorization is the approval that we advise you to seek before receiving certain *covered health care services*. *Preauthorization* ensures that services are *medically necessary* and performed in the most appropriate setting. *Network providers* are responsible for obtaining *preauthorization* for all applicable *covered health care services*.

You are responsible for obtaining *preauthorization* when the *provider* is *non-network* or if the services are rendered by a *provider* or facility that participates with an out-of-state Blue Cross or Blue Shield *plan (BlueCard)*. If you do not obtain *preauthorization* and the services are determined to be not *medically necessary* or the setting in which the services were received is determined to be inappropriate, we will not cover these services/facilities.

You may request *preauthorization* by telephoning us at (401) 459-5000 or 1-800-639-2227 for medical/surgical services and (401) 277-1344 or 1-800-274-2958 for behavioral health services. We must be contacted at least two (2) working days before you receive any *covered health care service* for which *preauthorization* is recommended. Services for which *preauthorization* is recommended are marked with an asterisk (*) in the Summary of Benefits.

PREVENTIVE CARE SERVICES means *covered health care services* performed to prevent the occurrence of disease. For the purpose of coverage under this agreement *preventive care services* are limited to:
- Adult preventive office visit and certain adult immunizations;
- Pediatric preventive office visits and pediatric immunizations;
- Travel immunizations; and
- Certain cancer screenings.

See Section 3.30 - Preventive and Early Detection Services and Section 3.24 – Office Visits for details. See the Summary of Medical Benefits for benefit limits and level of coverage.

PROGRAM means a collection of *covered health care services*, billed by a single *provider*, which can be administered in a variety of settings and by different *providers*. This agreement does NOT cover *programs* unless specifically listed as covered. See Section 3.0 - *Covered Health Care Services* to determine if a *program* is covered under this agreement.

PROVIDER means an individual or entity licensed under the laws of the State of Rhode Island or another State to furnish health care services. For purposes of this agreement the term *provider* includes a *doctor* and a *hospital* as well those individuals whose services we are required to cover under Title 27, Chapters 19 and 20 of the Rhode Island General Laws, as amended from time to time, such as midwives, certified registered nurse practitioners, psychiatric and mental health nurse clinical specialists practicing in collaboration with or in the employ of a physician licensed in Rhode Island, counselors in mental health, and therapists in marriage and family practice.

REHABILITATIVE SERVICES means acute short-term therapies that can only be provided by a qualified professional and are used to treat functional deficiencies that are the result of injury or disease. Short-term therapies are services that result in measurable and meaningful functional improvements within 60 days. These services must be consistent with the nature and severity of illness, be considered safe and effective for the patient's condition and be used to restore function. They must be provided as part of a defined treatment plan for an acute illness, injury, or an acute exacerbation of a chronic illness with significant potential for functional recovery. For the purpose of coverage under this agreement, See Section 3.35 Speech Therapy and the Summary of Benefits for benefit limits and level of coverage.

SEMI-PRIVATE ROOM means a *hospital* room with two or more patient beds.

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

SUBROGATION means that a third person or entity, such as an insurer, assumes the legal right of another person or entity, such as the insured, to collect all or part of a debt or damages. See Section 6.7, *Subrogation*.

SUBSCRIBER/MEMBER means you and each *eligible person* listed on your application whom we agree to cover.

URGENT CARE CENTER means a health care center physically separate from a *hospital* or other institution with which it is affiliated OR an independently operated and owned health care center. These centers are also 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 health care service* under this agreement.
Prospective Review is a review conducted prior to services being rendered.
Concurrent Review is a review conducted during a patient's *hospital* stay or course of treatment.
Retrospective Review is a review conducted after services have been rendered.

WE, US, and **OUR** means Blue Cross & Blue Shield of Rhode Island. We are located at 444 Westminster Street, Providence, Rhode Island, 02903. For the purpose of this agreement WE, US, or OUR will have the same meaning whether italicized or not.

YOU and **YOUR** means the individual who is subscribing to Blue Cross & Blue Shield of Rhode Island. For the purpose of this agreement YOU and YOUR will have the same meaning whether italicized or not.

Your Plan for Life™

www.BCBSRI.com

444 Westminster Street, Providence, RI 02903
Tel.: (401) 459-5000; 1-800-639-2227