# Subscriber Agreement

# Plan 65
# Medicare Supplement Plan Select G

**Medicare Supplement Subscriber Agreement**
This *subscriber agreement* (*agreement*) describes your *benefits* from Blue Cross & Blue Shield of Rhode Island (BCBSRI). This is a *Medicare* Supplement Insurance *Plan*, which provides supplemental coverage for *Original Medicare.*

To receive *benefits* under this *plan*, you must receive *Medicare* Part A health care services from the *Plan 65 Select Hospital Network*, except if the health services are for *emergency* treatment or the health services you require are not available in the *Plan 65 Select Hospital Network.*

To obtain a list of *hospitals* in the *Plan 65 Select Hospital Network,* please call the *Medicare* Concierge Team at the phone number located in the Contact Information section or visit our website, bcbsri.com.

**Renewable**
This *plan* begins on the effective date and remains in effect until December 31, 2018. You may renew this *plan* each *calendar year* by paying the required *subscriber* fee.

**Changes in Benefits**
*Benefits* under this *plan* will change automatically if *Medicare eligible expense*s change. *Subscriber* fees may increase or decrease to reflect a change in *benefits*. We will send you written notice describing the *benefit* change at least thirty (30) days prior to the effective date of a change.

**30 Day Right to Examine**
You have the right to return this *agreement* within thirty (30) days of receipt if you are not satisfied with it for any reason. We will refund your *subscriber* fee if this *agreement* is returned within that time period.

**Notice to Buyer**
This *plan* may not cover all of your medical expenses. Please read this entire *agreement* carefully.

Blue Cross Blue Shield of Rhode Island

**BLUE CROSS & BLUE SHIELD OF RHODE ISLAND**
**SUBSCRIBER AGREEMENT**

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## SUMMARY OF BENEFITS

This is your *subscriber agreement* for *Plan* 65 *Medicare* Supplement *Plan* Select G. This *subscriber agreement* replaces any previous *subscriber agreement* issued for this type of coverage. The Summary of *Benefits* is intended to give you a general understanding of *benefits* available under this *plan*. For more details, please read Section 3 for a description of coverage for specific *benefits* and Section 5 for a list of general exclusions.

This type of *Medicare* supplement policy requires you to use *hospitals* in the *Plan 65 Select Hospital Network* to be eligible for *Medicare* Part A inpatient *hospital benefits* except if:

- you require *emergency* treatment; or
- the health services you require are not available in the *Plan 65 Select Hospital Network.*

To obtain a list of *hospitals* in the *Plan 65 Select Hospital Network,* please call the *Medicare* Concierge Team at the phone number located in the Contact Information section or visit our website, bcbsri.com. This *plan* covers health services received from *doctors* that are *Medicare* providers.

The Summary of *Benefits* indicates how we pay *benefits* when you obtain *Medicare* Part A services from within the *Plan 65 Select Hospital Network*.

Note: Except as indicated above, if you receive services at a non-participating *Plan* 65 Select *hospital*, you will be responsible to pay the applicable *Medicare eligible expenses*, Part A *deductible* and/or Part A *copayment* and the amount you pay will not apply toward the out-of-pocket limit described below.

Please refer to Section 3: Covered Health Services for a detailed description of each *benefit*.

## Summary of Benefits

*Medicare* Part A helps pay for health care in *hospitals*, *skilled nursing facilities*, hospice care, and some home health care services. The table below shows how much *Medicare*, this *plan*, and you pay for specific services. Please note, you pay for any services not covered by *Medicare* A & B or *Plan* 65 *Medicare* Supplement *Plan* Select G.

| **Medicare Part A: Hospital Services per Benefit Period** | | | | |
|---|---|---|---|---|
| **Service** | **Limits** | **Medicare Pays** | **Plan Pays** | **You Pay** |
| **Hospitalization (*)** Semi-private room and board, general nursing and miscellaneous services and supplies | First 60 days | All but $1,408 | $1,408 (Part A *deductible*) | $0 |
| | Days 61 thru 90 | All but $352 per day | $352 per day | $0 |
| | Days 91 and after while using 60 lifetime reserve days | All but $704 per day | $704 per day | $0 |
| | Once lifetime reserve days are used, an additional 365 days | $0 | 100% of *Medicare eligible expenses* (**) | $0(**) |
| | Beyond the additional 365 days | $0 | $0 | 100% |
| **Skilled Nursing Facility (SNF) Care (*)** You must meet *Medicare's* requirements, including having been in a *hospital* for at least 3 days and entered a *Medicare*-approved facility within 30 days after leaving the *hospital* | First 20 days | All approved amounts | $0 | $0 |
| | Days 21 thru 100 | All but $176 per day | Up to $176 per day | $0 |
| | Days 101 and after | $0 | $0 | 100% |
| **Blood (inpatient)** | First 3 pints | $0 | 100% | $0 |
| | Additional amounts | 100% | $0 | $0 |
| **Hospice Care** You must meet *Medicare's* requirements, including a *doctor's* certification of terminal illness. | | All but very limited *copayment* or coinsurance for outpatient drugs and inpatient respite care | *Medicare copayment* or coinsurance for outpatient drugs and inpatient respite care | $0 |

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

(**) When your *Medicare* Part A *hospital benefits* are exhausted, BCBSRI stands in the place of *Medicare* and will pay whatever amount *Medicare* would have paid for up to an additional 365 days. During this time, the *hospital* is prohibited from billing you for the balance based on any difference between its billed charges and the amount *Medicare* would have paid.

*Medicare* Part B helps pay for *doctors*' services, outpatient *hospital* care, certain medically necessary home health care services and other medical services that Part A does not cover, such as physical and speech therapy. The table below shows how much *Medicare,* your *plan,* and you pay for specific services. Please note, you pay for any services not covered by *Medicare* A & B or *Plan* 65 *Medicare* Supplement *Plan* G.

| **Medicare Part B: Medical Services per Calendar Year** | | | | |
|---|---|---|---|---|
| **Service** | **Limits** | **Medicare Pays** | **Plan Pays** | **You Pay** |
| **Medical Expenses** Includes treatment in or out of the *hospital* and outpatient *hospital* treatment, such as: *doctor's* services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment | First $198 of *Medicare*-approved amounts(^) | $0 | $0 | $198 (Part B *deductible*) |
| | Remainder of *Medicare*-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above *Medicare*-approved amounts) | | $0 | 100% | $0 |
| **Blood** | First 3 pints | $0 | 100% | $0 |
| | Next $198 of *Medicare*-approved amounts(^) | $0 | $0 | $198 (Part B *deductible*) |
| | Remainder of *Medicare*-approved amounts | 80% | 20% | $0 |
| **Clinical Laboratory Services** | Tests for diagnostic services | 100% | $0 | $0 |
| **Medicare Parts A and B** | | | | |
| **Service** | **Limits** | **Medicare Pays** | **Plan Pays** | **You Pay** |
| **Home Health Care** *Medicare*-approved services | Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| **Durable Medical Equipment** *Medicare*-approved services | First $198 of *Medicare*-approved amounts(^) | $0 | $0 | $198 (Part B *deductible*) |
| | Remainder of *Medicare*-approved amounts | 80% | 20% | $0 |

^ Once you have been billed $198 of *Medicare*-approved amounts for covered services (which are noted with a carrot), your Part B *deductible* will have been met for the *calendar year*.

| Other Benefits – Not Covered by Medicare | | | | |
|---|---|---|---|---|
| **Service** | | **Medicare Pays** | **Plan Pays** | **You Pay** |
| **Foreign Travel- Not Covered by Medicare** Medically necessary *emergency* care services beginning during the first 60 days of each trip outside the USA | First $250 each *calendar year* | $0 | $0 | $250 |
| | Remainder of charges | $0 | 80% to a lifetime maximum *benefit* of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

Note: The Summary of *Benefits* contains only a brief summary of *Medicare benefits*. Please contact your local Social Security Office or consult the "*Medicare* & You" handbook for details about *Medicare*.

## SECTION 1: INTRODUCTION TO YOUR SUBSCRIBER AGREEMENT

Thank you for choosing BCBSRI for your *Medicare* supplement coverage. We appreciate the trust you've placed in us and want to help you make the most of your health *plan*.

In this *agreement*, you'll find valuable information about your *plan*, including:

- how your coverage works;
- how BCBSRI processes claims for the health services you receive;
- your rights and responsibilities as a *subscriber*;
- BCBSRI's rights and responsibilities.

We encourage you to read this entire *agreement* to learn about all the advantages of being a BCBSRI *subscriber*. The entire contract consists of the application, this *agreement*, and any attached amendments. Statements made by you to obtain insurance under this *agreement* will be deemed representations and not warranties.

### How to Use This Agreement

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

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

### Contact Us If You Have a Question

If you have questions about your *benefits* or anything in this *agreement*, we are happy to help. Simply call the *Medicare* Concierge Team or visit one of our Your Blue Store locations. As a BCBSRI *subscriber*, you may also log in to our secure website to find out BCBSRI news, get *plan* information or use many of our self-service options.

### Your Identification (ID) Card

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

Tips for keeping your card safe:

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

## SECTION 2: ELIGIBILITY

### Who Is an Eligible Person

**You**

You are eligible to enroll if:

- you are a *Medicare* recipient enrolled in *Original Medicare*; and
- you reside in Rhode Island.

Note: You can only be covered under one (1) *Medicare* supplement *plan* at a time. If you were to enroll in another *Medicare* supplement *plan* or a *Medicare* Advantage *plan*, we recommend that you disenroll from this *plan*. If you are enrolled in a *Medicare* supplement *plan* and a *Medicare* Advantage *plan* at the same time, only *Medicare* Advantage *benefits* are provided.

### Medicaid Eligibility

If you become eligible for *Medicaid*, you may request that we suspend coverage under this *plan.* To suspend coverage, notify us within ninety (90) days of the date you become entitled to *Medicaid.* Upon receipt of this notice, we will suspend *benefits* and *subscriber* fees due under this *plan* for up to twenty-four (24) months.

This *plan,* or if this *plan* is no longer available, a *plan* that is a substantially equivalent, can be automatically reinstated within the twenty-four (24) month period if you:

- are no longer eligible for *Medicaid;* and
- notify us within ninety (90) days of the date you are no longer eligible for *Medicaid*; and
- pay *subscriber* fees due as of the date of reinstatement.

Your effective date of reinstatement is the date you cease to be eligible for *Medicaid. Benefits* and *subscriber* fees will be reinstated as if your *plan*, or a substantially equivalent *plan*, had remained in force. Any *benefit* or *subscriber* fee changes made to your *plan*, while your coverage was suspended, are effective as of your reinstatement date.

### When Your Coverage Ends

**When This Agreement Ends**

Coverage under this *agreement* is guaranteed renewable. It will automatically renew on the *plan* renewal date of January 1. It can only be canceled for one of the following reasons:

- the *subscriber* fee is not paid within (1) month of the due date; or
- fraud is determined by us.

**Reinstatement**

We have the right to reinstate a terminated *agreement*.

**When You End This Agreement**

You may terminate this *agreement* by telling us in writing.

### Extension of Benefits

If you are disabled on the date your coverage ends, your *benefits* will be temporarily extended for any continuous loss, which commenced while your coverage was in force. 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 your coverage ended.

If you want to receive coverage for continued care when your coverage ends, you must provide us with proof that you are disabled. We will make a determination whether your condition constitutes a disability and you will have the right to appeal our determination or to take legal action.

The extension of *benefits* will end upon the earliest of the following events:

- you are no longer totally disabled;
- the *Medicare benefit period* ends; or
- maximum *benefit* payments have been paid.

**Subscriber Fees**

Your *subscriber* fee will be billed to you and the bill will indicate the due date of your payment. The following may also apply to your *subscriber* fee.

**Tobacco Products**

*Subscribers* enrolled in this *plan* with an effective date on or after May 1, 2016 are billed their *subscriber* fee based upon whether they have used tobacco products in the previous twelve (12) months. The *subscriber* fee for a *subscriber* that does not use tobacco products is lower than the *subscriber* fee for a *subscriber* that uses tobacco products.

To be eligible for the non-tobacco *subscriber* fee, you must complete an attestation. Please call the *Medicare* Concierge Team to request a Tobacco Attestation form. Contact information is in Section 9.

The non-tobacco *subscriber* fee will be effective on the first of the month following receipt of the Tobacco Attestation form if the form is returned to us by the 15th day of the prior month. We may discontinue this non-tobacco use *subscriber* fee, in our discretion, concurrent with an Office of the Health Insurance Commissioner (OHIC) filed and approved *subscriber* fee rate change. We will provide prior written notice of such discontinuance to you.

**Electronic Funds Transfer (EFT)**

You can have a $2.00 per month discount applied to your *subscriber* fee by paying your *subscriber* fee through an electronic funds transfer (EFT). Funds are withdrawn electronically from your checking or savings account.

To have the $2.00 EFT monthly discount applied, you must complete an EFT form and submit it us by the 13th day of month prior to your chosen effective date. Please call the *Medicare* Concierge Team to request an EFT form be sent to you. Contact information is in Section 9.

## SECTION 3: COVERED HEALTH SERVICES

This *plan* covers certain *copayments* and *deductibles* required by *Medicare.*
This *plan* does not cover all of your medical expenses. Please read this entire *agreement* carefully.

**Medicare Part A: Hospital Services per Benefit Period**

This *plan* covers *Medicare* Part A inpatient *hospital* services when you have services performed at a *hospital* that participates in the *Plan 65 Select Hospital Network.*

Inpatient *hospital* services received from a *hospital* that is not a part of the *Plan 65 Select Hospital Network* are not covered, unless the services are required for *emergency* treatment or the services are not available within the *Plan 65 Select Hospital Network.*

Except as indicated above, if you receive services at a non-participating *Plan* 65 Select *hospital,* you will be responsible to pay the applicable *Medicare eligible expenses,* Part A *deductible* and/or Part A *copayment.*

To obtain a listing of the *Plan 65 Select Hospital Network* listing, please call the *Medicare* Concierge Team or visit our website. Contact information is in Section 9.

**Hospitalization/Inpatient Hospital Services at a Plan 65 Select Hospital**
The *Medicare* Part A inpatient *hospital deductible* for *Medicare eligible expenses* for your first sixty (60) days of inpatient hospitalization per *benefit period* is covered.

This *plan* covers the *Medicare* Part A *copayment* for *Medicare eligible expenses* for the 61st through 90th day of your inpatient hospitalization.

**Lifetime Inpatient Reserve Days at a Plan 65 Select Hospital**
If you are hospitalized for more than ninety (90) days, this *plan* covers the *Medicare* Part A *copayment* for *Medicare eligible expenses* relating to the 91st to 150th day of lifetime inpatient reserve days. Lifetime inpatient *hospital* reserve days are limited to sixty (60) additional days of inpatient hospitalization once in your lifetime.

**Lifetime Maximum Benefit for Inpatient Hospital Days at a Plan 65 Select Hospital**
If you exhaust all *Medicare hospital* inpatient coverage, including the lifetime inpatient reserve days, this *plan* covers *Medicare eligible expenses* for hospitalization, subject to a lifetime maximum *benefit* of three hundred sixty-five (365) days. Your healthcare expenses will be paid as follows:

- to the same extent and in the same amount that *Medicare* would have covered such services had the lifetime reserve days not been exhausted and *Medicare* remained your primary *plan*; or
- the lesser of (a) above or the *hospital's* charges for services.

**Skilled Nursing Facility (SNF) Care**
Subsequent to an inpatient *hospital* stay, this *plan* covers the *Medicare* Part A *copayment* for *Medicare eligible expenses* for a *SNF* from the 21st day through the 100th day in a *Medicare benefit period.*

Note: The *Plan 65 Select Hospital Network* does not apply to *SNFs*.

**Blood Services (Inpatient)**
This *plan* covers the replacement costs, if any, required by *Medicare* for the first three (3) pints of blood (or equivalent quantities of packed red blood cells as defined under federal regulations), unless the blood is replaced in accordance with federal regulations.

**Hospice Care**
This *plan* pays the *Medicare copayment* for hospice care and respite care *Medicare eligible expenses*.

**<u>Medicare Part B: Medical Services per Calendar Year</u>**
**Medical Expenses**
This *plan* covers the *Medicare* Part B *copayment* for *Medicare eligible expenses.*

**Medicare Part B Excess Charges**
This *plan* covers *excess charges,* which is the difference between the amount a *doctor (*or other healthcare provider) charges and the amount that *Medicare* pays. *Excess charges* may not be more than any charge limitation established by *Medicare* or state law.

**<u>Foreign Travel - Not Covered by Medicare</u>**
This *plan* covers *Medicare eligible expenses* for medically necessary *emergency* services rendered in in a foreign country if *Medicare* would have covered the services as *Medicare eligible expenses* had the *emergency* happened in the United States.

In addition, the following conditions must be met:

- health services are not eligible for payment under any *Medicare* program;
- *emergency* care is received during the first sixty (60) days of a trip outside the United States; and
- *emergency* care is *received* on or after the effective date of your *plan*.

*Benefits* for *emergency* medical care in foreign countries are payable to you only in United States currency. The amount paid to you is based on the bank transfer exchange rate in effect the date the services were rendered.

You may be required to pay up front for the *emergency* services at the time of service. You are then responsible to complete a foreign claim research form and a claim form and submit both to us for processing. To obtain forms, please call the *Medicare* Concierge Team. See Section 9 for contact information.

To file a claim, please send us the itemized bill for the healthcare service, a completed foreign claim research form, and a claim form with the following information:
- your name;
- your *Plan* 65 *subscriber* ID number;
- name, address, and telephone number of the provider who performed the service;
- date and description of the service; and
- the charge for the service.

Please send to the address listed in Section 9: Contact Information.

Claims must be filed within twelve (12) months of the date you receive a healthcare service.

## SECTION 4: CHANGES IN BENEFITS

The *benefits* indicated in Section 3, Covered health services, will change automatically if *Medicare eligible expenses* are revised. We will send written notice to you with a description of the *benefit* change(s) at least thirty (30) days prior to the effective date of the change. The effective date will be the same date that *Medicare* implements *benefit* change(s) to *Original Medicare*. *Subscriber* fees may be increased or decreased to reflect any change to *benefits* under this *plan*.

If this *plan* changes, we will issue an amendment or a new *subscriber agreement*. Payment of your *subscriber* fee is considered acceptance by you of the change.

## SECTION 5: GENERAL EXCLUSIONS

**Amounts Payable Under Medicare**

Payments made under this *plan* will not duplicate any amounts payable under *Medicare*.

**Benefits Not Listed In the Summary of Benefits**

This *plan* will not cover any *benefit* that is not listed in the Summary of *Benefits*. A *benefit* in the Summary of *Benefits* is covered only to the extent described in this *agreement*.

**Care Provided by Non-Participating Plan 65 Select Hospitals**

No *benefits* are provided for inpatient *hospital* services when you do not use a *hospital* that participates in the *Plan 65 Select Hospital Network*, unless the inpatient *hospital* services are required for *emergency* treatment or the services are not available within the *Plan 65 Select Hospital Network*.

**Care Provided Without Charge**

No *benefits* are provided for services when there is no charge to you or there would have been no charge absent this coverage.

**Workers' Compensation**

This *plan* will not cover any injury or sickness, for which you are entitled to, *benefits* under workers' compensation or similar law.

## SECTION 6: CLAIM FILING AND SUBROGATION

### How to File a Claim

Most providers will submit claims directly to *Medicare* on your behalf. *Medicare* processes the claim, sends you a *Medicare* Summary Notice, and sends the claim information directly to us. The claim is processed by us and *Medicare eligible expenses* covered under this *plan* are then paid to the provider.

If a provider does not file a claim on your behalf, you will need to file it. To file a claim, please send us a copy of the *Medicare* Summary Notice and include your *Plan* 65 *subscriber* ID number.

Please send your claim to the address listed in the Section 9: Contact Information.

Claims must be filed within twelve (12) months of the date the claim was processed by *Medicare* as indicated on the *Medicare* Summary Notice. Claims submitted after this deadline are not eligible for reimbursement. This timeframe does not apply if you are legally incapacitated.

### Payment of Benefits

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

### Our Right of Subrogation and/or Reimbursement

**Subrogation**

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

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

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

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

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

**Reimbursement**

In addition to the subrogation rights described above, we also have reimbursement rights. If you recover money by lawsuit, settlement, or otherwise, we may seek reimbursement from you for covered healthcare services for

which we paid or will pay. Our reimbursement right applies when you received payment from a third party for covered healthcare services we provided under this *plan*, as described in the subrogation section above.

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

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

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

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

**Subscriber Cooperation**

You further agree:

- to notify us promptly and in writing when notice is given to any third party or representative of a third party of the intention to investigate or pursue a claim to recover damages or obtain compensation;
- to cooperate with us and provide us with requested information;
- to do whatever is necessary to secure our rights of subrogation and reimbursement under this *plan*;
- to assign us any *benefits* you may be entitled to receive from a third party. Your assignment is up to the cost of the covered healthcare services;
- to give us a first priority lien on any recovery, settlement, or judgment or other source of compensation which may be had by any third party. You agree to do this to the extent of the full cost of all covered healthcare services associated with third party responsibility;
- to do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of the covered healthcare services provided by this *plan*;
- to serve as a constructive trustee for the benefit of this *plan* over any settlement or recovery funds received as a result of third party responsibility;
- that we may recover the full cost of the covered healthcare services provided by this *plan* without regard to any claim of fault on your party, whether by comparative negligence or otherwise;
- that no court costs or attorney fees may be deducted from our recovery;
- that we are not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your claim or lawsuit against any third party; and
- that in the event you or your representative fails to cooperate with us, you shall be responsible for all costs associated with covered healthcare services provided by this *plan*, in addition to costs and attorney fees incurred by this *plan* in obtaining repayment.

## SECTION 7: REQUESTS FOR AUTHORIZATION, DENIALS, COMPLAINTS, AND APPEALS

**Requests for Network Authorization**

**Network Authorization**

For inpatient services that cannot be provided by a *hospital* that participates in the *Plan 65 Select Hospital Network*, you can request a *network authorization* to seek services from a *hospital* that does not participate in

the *Plan 65 Select Hospital Network*. With an approved *network authorization*, the inpatient services will be reimbursed as if you had received services at a participating *Plan* 65 Select *hospital* and the applicable *Medicare eligible expenses*, Part A *deductible* and/ or Part A *copayment* will be paid by us.

**Denials**

A claim denial, also known as an adverse *benefit* determination, is any of the following:

- a full or partial denial of a *benefit*;
- a reduction of a *benefit*;
- a termination of a *benefit*;
- a failure to provide or make a full or partial payment for a *benefit*; and
- a rescission of coverage, even if there is no adverse effect on any *benefit*.

If we deny payment for a service we determine not medically necessary, a determination letter will be provided with the following information:

- reason for the denial;
- clinical criteria used to make the determination as well as how to obtain a copy of the clinical criteria; and
- instructions for filing a medical appeal.

If you have questions, please contact our Grievance and Appeals Unit. See Section 9 for contact information. You may also contact the Office of the Health Insurance Commissioner's Consumer Resource Program, RIREACH at 1-855-747-3224 about questions or concerns you may have.

**Complaints**

A complaint is an expression of dissatisfaction with any aspect of our operation or the quality of care you received from a healthcare provider. It is not an appeal, an inquiry, or a problem of misinformation which can be resolved promptly by clearing up the misunderstanding, or supplying the appropriate information to your satisfaction.

We encourage you to discuss any concerns or issues you may have about any aspect of your medical treatment with the healthcare provider that furnished the care. In most cases, issues can be more easily resolved if they are raised when they occur. However, if you remain dissatisfied or prefer not to take up the issue with your provider, you can call our *Medicare* Concierge Team for further assistance. You may also call our *Medicare* Concierge Team if you are dissatisfied with any aspect of our operation.

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

We will acknowledge receipt of your complaint or administrative appeal within ten (10) business days. The Grievance and Appeals Unit will conduct a thorough review of your complaint and respond within thirty (30) business days of the date it was received. The determination letter will provide you with the rationale for our response as well as information on any possible next steps available to you.

When filing a complaint, please provide the following information:

- your name, address, *subscriber* ID number;
- the date of the incident or service;
- summary of the issue;
- any previous contact with BCBSRI concerning the issue;
- a brief description of the relief or solution you are seeking; and
- additional information such as referral forms, claims, or any other documentation that you would like us to review.

Please send all information to the address listed on the Contact Information section.

## Appeals

If you experience a problem relating to a *benefit* denial from *Medicare*, please refer to the appeals process information provided to you in the denial letter you received from *Medicare*.

If you experience a problem relating to a *benefit* denial or other aspect of this *Medicare* supplement *plan*, please refer to the Administrative Appeals section below. When filing an appeal, please reference the same information listed in the Complaints section above.

### Administrative Appeals

An administrative appeal is a request for us to reconsider a full or partial denial of payment for covered healthcare services for the following reasons:

- the services were excluded from coverage;
- we determined that you were not eligible for coverage;
- you or your provider did not follow BCBSRI's requirements; or
- a limitation on an otherwise covered *benefit* exists.

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

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

We will acknowledge receipt of your administrative appeal within ten (10) business days. The Grievance and Appeals Unit will conduct a thorough review of your administrative appeal and respond within:

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

### Medical Appeals

If you disagree with a full or partial medical denial made by *Medicare*, you may dispute the decision through the *Medicare* appeals process. To start this process, follow the directions given in the letter you receive from *Medicare* about the denial. We do not process *Medicare* medical appeals.

In the event we deny payment of an amount for which this *plan* is responsible for a medical reason, you may dispute the denial with us.

A medical appeal under this *plan* is a request for us to reconsider a full or partial denial of payment for services because we determined:

- the service was not medically necessary or appropriate; or
- the service was experimental or investigational.

You may request an expedited appeal when:

- an urgent preauthorization request for healthcare services has been denied;
- the circumstances are an *emergency*; or
- you are in an inpatient setting.

#### How to File a Medical Appeal

You or your physician may file a written or verbal medical appeal with our Grievance and Appeals Unit. The medical appeal must be submitted to us within one hundred and eighty (180) calendar days of the initial determination letter.

If someone other than your provider is filing a medical appeal on your behalf, you must provide us with a signed notice, authorizing the individual to represent you in this matter.

Within ten (10) business days of receipt of a written or verbal medical appeal, the Grievance and Appeals Unit will mail or call you to acknowledge our receipt of the medical appeal.

You will receive written notification of our determination within thirty (30) calendar days, from the receipt of your appeal.

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

**How to File an Expedited Appeal**

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

To request an expedited appeal of a denial related to services that have not yet been rendered (a preauthorization review), you or your healthcare provider should call our Grievance and Appeals Unit. See Section 9 for contact information.

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

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

**How to Request an External Appeal**

If you remain dissatisfied with our medical appeal determination, you may request an external review by an outside review agency. Your claim does not have to meet a minimum dollar threshold in order for you to be able to request an external appeal.

To request an external appeal, submit a written request to us within four (4) months of your receipt of the medical appeal denial letter. We will forward your request to the outside review agency within five (5) business days, unless it is an urgent appeal, and then we will send it within two (2) business days.

We may charge you a filing fee up to $25.00 per external appeal, not to exceed $75.00 per *plan* year. We will refund you if the denial is reversed and will waive the fee if it imposes an undue hardship for you.

Upon receipt of the information, the outside review agency will notify you of its determination within ten (10) calendar days, unless it is an urgent appeal, and then you will be notified within seventy-two (72) hours.

The determination by the outside review agency is binding on us.

Filing an external appeal is voluntary. You may choose to participate in this level of appeal or you may file suit in an appropriate court of law (see Legal Action, below).

Once a member or provider receives a decision at one of the several levels of appeals noted above, (initial or external appeal), the member or provider may not ask for an appeal at the same level again, unless additional information that could affect such decisions can be provided.

**Legal Action**

If you are dissatisfied with the determination of your claim, and have complied with applicable state and federal law, you are entitled to seek judicial review. This review will take place in an appropriate court of law.

Under state law, 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.

## SECTION 8: GLOSSARY

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

***BENEFIT*** means the amount paid under this *plan* to supplement *Medicare eligible expenses*.

***CALENDAR YEAR*** means a twelve (12) month period beginning on January 1 and ending December 31.

***COPAYMENT*** means the amount *Medicare* requires that you pay for covered *benefits*.

***DEDUCTIBLE*** means the amount *Medicare* requires that you pay before *Medicare* will provide covered *benefits*.

***DOCTOR*** means any person licensed and registered as an allopathic or osteopathic physician (i.e. D.O or M.D.).

***EMERGENCY*** means a medical condition manifesting itself by acute symptoms. The acute symptoms are severe enough (including severe pain) that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that without immediate medical attention serious jeopardy to the health of a person (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 could result.

***EXCESS CHARGE*** means the dollar amount a *doctor* (or other healthcare provider) charges that is more than the *Medicare*-approved amount. The difference between the *doctor's* charge and the *Medicare*-approved amount is the *excess charge*.

***HOSPITAL*** means a facility:

- 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 mean:

- convalescent home;
- rest home;
- nursing home;
- home for the aged;
- school and college infirmary;
- residential treatment facility;
- long-term care facility;

- urgent care center or freestanding ambulatory surgical center;
- facility providing mainly custodial, educational or rehabilitative care; or a section of a *hospital* used for custodial, educational or rehabilitative care, even if accredited by the JCAHO or listed in the AHA directory.

***MEDICAID*** means "The Health Insurance for the Aged Act", Title XIX of the United States Social Security Amendments of 1965, as amended.

***MEDICARE*** means "The Health Insurance for the Aged Act", Title XVIII of the United States Social Security Amendments of 1965, as then constituted or later amended.

***MEDICARE BENEFIT PERIOD (BENEFIT PERIOD)*** means the way in which *Original Medicare* measures your use of *hospital* and *skilled nursing facility (SNF)* services. A *Medicare benefit period* begins the day you are admitted as an inpatient in a *hospital* or *SNF*. The *Medicare benefit period* ends when you have not received any inpatient *hospital* care or skilled care in a *SNF* for sixty (60) days in a row. If you go into a *hospital* or a *SNF* after one *Medicare benefit period* has ended, a new *Medicare benefit period* begins. An inpatient *hospital deductible* applies to each *Medicare benefit period*. There is no limit to the number of *benefit periods* you can have.

***MEDICARE ELIGIBLE EXPENSE*** means healthcare expenses which are covered by *Original Medicare.*

***NETWORK AUTHORIZATION*** is the process of obtaining an approval from us to receive healthcare services from a *hospital* that does not participate in the *Plan 65 Select Hospital Network.*

***ORIGINAL MEDICARE*** is the *Medicare* traditional fee-for-service federal health insurance. It has two parts, *Medicare* Part A (*hospital* insurance) and *Medicare* Part B (medical insurance).

***PLAN*** means this health insurance *benefit* package. There are ten (10) separate *Medicare* supplement *plans* allowed by law. All ten (10) are listed in the *plan* chart attached to this *agreement*. We may offer fewer than ten (10) separate *plans*. We may also offer the same *plan* with and without limited provider network restrictions. Your *plan* is the *plan* shown in the Summary of *Benefits*.

***PLAN 65 SELECT HOSPITAL NETWORK*** means *hospitals* that have entered into an agreement with us to accept *Original Medicare's* payment as full payment for health services. You are not obligated to pay the *Medicare* Part A *copayment* and/or *deductible* amounts for *Medicare* Part A healthcare services covered under this *plan* if you receive inpatient services at a *Plan 65 Select Hospital Network facility.*

***SKILLED NURSING FACILITY*** means a facility which primarily provides skilled nursing care under the supervision of a *doctor*. Room and board accommodations is provided as well. A *skilled nursing facility* must:
- provide continuous 24-hour a day nursing services by or under the supervision of a registered graduate professional nurse (R.N.);
- maintain the daily medical record of each patient; and
- be approved or qualified to receive *Medicare benefits*.

*A skilled nursing facility* does not include a home or facility which is used:
- primarily for rest;
- to care for the aged or for the care of substance abuse treatment; or
- primarily for the care and treatment of mental diseases or disorders, or custodial or educational care.

***SUBSCRIBER*** means you, the person who enrolls in this *plan* and signs the application.

***WE***, ***US***, and ***OUR*** means BCBSRI. 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 *subscriber* whose application for coverage under this *agreement* has been approved by us. For the purpose of this *agreement*, *YOU* and *YOUR* will have the same meaning whether italicized or not.

## SECTION 9: CONTACT INFORMATION

**Medicare Concierge Team and Network Authorization**
In state: (401) 277-2958
Out of state: 1-800-267-0439
Hearing impaired: 711
Business hours are Monday thru Friday 8 a.m. to 8 p.m. and Saturday and Sunday 8 a.m. to noon. You can use our automated answering system outside of these hours.

**Website**
www.bcbsri.com

**Claim Filing Mailing Address**
Blue Cross & Blue Shield of Rhode Island
Attention: Claims Department
500 Exchange Street
Providence, RI 02903

**Appeal Submission**
Blue Cross & Blue Shield of Rhode Island
Attention: Grievance and Appeals Unit
500 Exchange Street
Providence, RI 02903

Fax: 401-459-5005

**Your Blue Store**
You may also visit one of our retail walk-in service centers. Please check our website for specific locations and business hours.

**Emergency Care**
If you need *emergency* care, call 911 or go to the nearest *hospital emergency* room.

## SECTION 10: NOTICES AND DISCLOSURES

**Our Right to Receive and Release Information About You**
We are committed to maintaining the confidentiality of your dental information. However, in order for us to make available quality, cost-effective dental coverage to you, we may release and receive information about your health, treatment, and condition to or from authorized *dentists* and insurance companies, among others. We may give or get this information, as permitted by law, for certain purposes, including, but not limited to:

- adjudicating dental insurance *claims*;
- administration of *claim* payments;
- dental operations;
- case management and *utilization review*;
- coordination of dental coverage; and
- health oversight activities.

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

## SECTION 11: BENEFIT CHART OF MEDICARE SUPPLEMENT PLANS SOLD

**Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010.**

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state. Medicare Supplement Plans A, F, G, N and Select F are currently being offered by Blue Cross & Blue Shield of Rhode Island.

**Basic Benefits:**

- **Hospitalization:** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses:** Part B coinsurance (generally 20% of Medicare - approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or co-payments.
- **Blood:** First three pints of blood each year.
- **Hospice:** Part A coinsurance.

| Plan A | Plan B | Plan C | Plan D | Plan F | Plan F* | Plan G | Plan K | Plan L | Plan M | Plan N |
|---|---|---|---|---|---|---|---|---|---|---|
| Basic, including 100% Part B co-insurance | Basic, including 100% Part B co-insurance | Basic, including 100% Part B co-insurance | Basic, including 100% Part B co-insurance | Basic, including 100% Part B co-insurance | | Basic, including 100% Part B co-insurance | Hospitalization and preventive care paid at 100%; other basic benefits paid at 50% | Hospitalization and preventive care paid at 100%; other basic benefits paid at 75% | Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER |
| | | Skilled nursing facility co-insurance | Skilled nursing facility co-insurance | Skilled nursing facility co-insurance | | Skilled nursing facility co-insurance | 50% Skilled nursing facility co-insurance | 75% Skilled nursing facility co-insurance | Skilled nursing facility co-insurance | Skilled nursing facility co-insurance |
| | Part A deductible | Part A deductible | Part A deductible | Part A deductible | | Part A deductible | 50% Part A deductible | 75% Part A deductible | 50% Part A deductible | Part A deductible |
| | | Part B deductible | | Part B deductible | | | | | | |
| | | | | Part B excess (100%) | | Part B excess (100%) | | | | |
| | | Foreign travel emergency | Foreign travel emergency | Foreign travel emergency | | Foreign travel emergency | | | Foreign travel emergency | Foreign travel emergency |
| ***Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,340 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2,340. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.** | | | | | | | Out-of-pocket limit $5,880; paid at 100% after limit reached | Out-of-pocket limit $2,940; paid at 100% after limit reached | | |

# Nondiscrimination and Language Assistance

Blue Cross & Blue Shield of Rhode Island (BCBSRI) complies with applicable Federal civil rights laws and does not discriminate or treat people differently on the basis of race, color, national origin, age, disability, or sex.

BCBSRI provides free aids and services to people with disabilities and to people whose primary language is not English when such services are necessary to communicate effectively with us.

If you need these services, contact us at 800-639-2227.

If you believe that BCBSRI has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Director of Grievance and Appeals Department, Blue Cross & Blue Shield of Rhode Island, 500 Exchange Street, Providence RI 02903, or by calling 401-459-5000 or 800-639-2227 (TTY/TDD: 888-252-5051). You can file a grievance in person, by phone or by mail, fax at 401-459-5005, or electronically through our member portal at bcbsri.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

**English:** If you, or someone you're helping, has questions about Blue Cross & Blue Shield of Rhode Island, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-639-2227.

**Spanish:** Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross & Blue Shield of Rhode Island, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-639-2227.

**Portuguese:** Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue Cross & Blue Shield of Rhode Island, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-800-639-2227.

**Chinese:** 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross & Blue Shield of Rhode Island 方面 的問題，您有權利免費以您的母語得到幫助和訊息. 洽詢一位翻譯員，請撥電話在此插入數字 1-800-639-2227.

**French Creole:** Si oumenm oswa yon moun w ap ede gen kesyon konsènan Blue Cross & Blue Shield of Rhode Island, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-800-639-2227.

**Cambodian-Mon-Khmer:** ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងតែជួយ មានសំណួរអំពី Blue Cross & Blue Shield of Rhode Island ទេ, អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មាន នៅក្នុងភាសា របស់អ្នក ដោយមិនអស់ប្រាក់ ។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូម 1-800-639-2227.

**French:** Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross & Blue Shield of Rhode Island, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-639-2227.

**Italian:** Se tu o qualcuno che stai aiutando avete domande su Blue Cross & Blue Shield of Rhode Island, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-639-2227.

**Laotian:** ຖ້າທ່ານ, ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບ Blue Cross & Blue Shield of Rhode Island, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-800-639-2227.

**Arabic:** إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross & Blue Shield of Rhode Island، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.
للتحدث مع مترجم اتصل بـ 1-800-639-2227.

**Russian:** Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross & Blue Shield of Rhode Island, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-639-2227.

**Vietnamese:** Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross & Blue Shield of Rhode Island, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-639-2227.

**Kru:** I bale we, tole mut u ye hola, a gwee mbarga inyu Blue Cross & Blue Shield of Rhode Island, U gwee Kunde I kosna mahola ni biniiguene I hop wong nni nsaa wogui wo. I Nyu ipot ni mut a nla koblene we hop, sebel 1-800-639-2227.

**Ibo:** Ọ bụrụ gị, ma o bụ onye I na eyere-aka, nwere ajụjụ gbasara Blue Cross & Blue Shield of Rhode Island, I nwere ohere iwenta nye maka na ọmụma na asụsụ gị na akwu gị ụgwọ. I chọrọ I kwụrụ onye-ntapịa okwu, kpọ 1-800-639-2227.

**Yoruba:** Bí ìwọ, tàbí ẹnikẹni tí o n ranlọwọ, bá ní ibeere nípa Blue Cross & Blue Shield of Rhode Island, o ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ongbufọ kan sọrọ, pè sórí 1-800-639-2227.

**Polish:** Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Blue Cross & Blue Shield of Rhode Island, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-639-2227.

**Korean:** 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Blue Cross & Blue Shield of Rhode Island 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-800-639-2227 로 전화하십시오.

**Tagalog:** Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross & Blue Shield of Rhode Island, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-800-639-2227.

This notice is being provided to you in compliance with federal law.