Consumer's Right to Know About Health Plans in Rhode Island

VantageBlue Select

BLUE CROSS & BLUE SHIELD of RHODE ISLAND
January 1, 2016

Consumer Disclosure

Safe and Healthy Lives in Safe and Healthy Communities

Consumer Disclosure

CONSUMER'S RIGHT TO KNOW ABOUT HEALTH PLANS
VantageBlue Select
Effective Date of Disclosure: August 1, 2016

THE HEALTH CARE ACCESSIBILITY AND QUALITY ASSURANCE ACT

WHY ARE YOU GETTING THIS INFORMATION?

- Knowing how Health Plans work helps you to be a better consumer.
- Meets State Law requiring Health Plans to disclose information.
- Provides information about your specific Health Plan.
- Informs you that a comprehensive list of all participating providers is available to you on the Health Plan Web Site (Hard copies available on request.)

Another document, the *Consumer's Guide to Health Plans in Rhode Island*, gives general information about health plans, including standard definitions of common terms, and is available upon request from Health Plan representatives. This document can also be found on the RI Department of Health Web Site:
http://www.health.ri.gov/publications/guides/ConsumersGuideToHealthPlansInRhodeIsland.pdf

This Consumer Disclosure has been reviewed and approved by the Rhode Island Department of Health in accordance with R23-17.13 (Rules and Regulations for Certifying Health Plans). Requests for more information about Health Plan certification or consumer rights may be addressed to:

> Rhode Island Department of Health, Office of Managed Care Regulation, 3 Capitol Hill, Providence, RI 02908-5097, Phone: 401 222-6015.

Q **Who can I contact at the Health Plan for information?** Representatives of this Health Plan are available to help you get the information you need. You can contact a Health Plan representative at:

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Blue Cross & Blue Shield of Rhode Island
Customer Service Department
500 Exchange Street
Providence, RI 02903 - 2699

From outside RI: 1-800-639-2227; From inside RI: 401-459-5000; Fax: 401-459-2006; TDD 711; Internet: www.BCBSRI.com Para contactor a un representante que hable Espanol, llame a: Departamiento de Servicios Para Miembros 1-800-639-2227. These phone numbers may be used to confirm the status of any provider, receive administrative or appeal process information, file a complaint, or receive timely access information.

Q **How does the Health Plan review and approve covered services?** A Health Plan may review covered services that are recommended by providers to decide if the services are medically necessary. If the plan decides the service is not medically necessary, it will not pay. You and your provider can appeal the Health Plan's decision. For more information about appeals see the Consumer's Guide to Health Plans in Rhode Island.

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We may review medical necessity before, during, or after the receipt of services. We may examine any required documents to determine if services are:

- appropriate and effective for the diagnosis, treatment, or care of the condition, disease ailment or injury for which it is prescribed or performed;
- appropriate with regard to generally accepted standards of medical practice within the medical community or scientific evidence;
- not primarily for the convenience of the *member*, the *member's* family or *provider* of such *member;* and
- the most appropriate in terms of type, amount, frequency, setting, duration, supplies or level of service which can safely be provided to the *member*, i.e. no less expensive professionally acceptable alternative is available.

We contract with a separate certified review agent who reviews and approves covered mental health and substance abuse services.

You may appeal any review decision within 180 days of receipt of the determination. We will review your appeal and respond to you within 15 days of receipt of all necessary information. If your appeal is denied, you may request a second appeal under the same terms. If your second appeal is denied, you may request an external appeal. An external appeal is performed by an agency that is not affiliated with us. An expedited appeal process is available if the circumstances are urgent or you are in an inpatient setting, which will be decided within 72 hours or two business days, whichever is shorter.

Q **What if I have an emergency?** An emergency is a problem that needs to be addressed by a provider "right-away" to prevent permanent damage or death. Here's what this Health Plan wants you to do when you have an emergency health care problem, at home or out of state.

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If you have an emergency:

- **Go** to the nearest hospital emergency room within twenty-four hours of the emergency.
- **Call** your regular doctor as soon as possible after your emergency room visit to arrange any required follow-up care.
- **Notify** the plan within 24 hours or as soon as reasonably possible if you are admitted from the emergency room to a non-network hospital.

Q **What if I refuse a referral to a participating provider? (a doctor, nurse, or other health professional in your Health Plan's network)** (not applicable to single service Health Plans) When a specific covered service is recommended, Health Plans may send you to certain participating providers. If you refuse the referral and get the service from another provider, the Health Plan must tell you what effect it will have on payment.

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Members may seek care without referral from in-network participating hospitals, primary care doctors, and specialists and receive coverage for eligible services less any copayments or coinsurance. Members may seek care without referral from participating providers outside the network and receive coverage for eligible services but with a higher copayment or coinsurance. Services provided by non-participating, out of network providers, are not covered.

Q **Does the Health Plan require that I get a second opinion for any services? What if I want a second opinion?** In some cases the Health Plan may require a second opinion before it will pay for a covered service. Or you may just want a second opinion on a plan for diagnosis or treatment.

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This Health Plan does not require you to get a second opinion.

The Health Plan will cover a second opinion if you request one. You may be required to pay part of the cost.

Q **How does the Health Plan make sure that my personal health information is protected and kept confidential?** In general, personal health information must be kept confidential (private) by a Health Plan, its employees and agencies it contracts with. Here's how the Health Plan makes sure that personal health information is protected.

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We will release information about your health, treatment, or condition to authorized doctors, health care providers, facilities, vendors, and insurers to coordinate your benefits and process claims. Access to personally identifiable information is limited to persons who need to know. Our employees are instructed to keep such information confidential and sign a statement promising to do so. Violation of a member's confidentiality or privacy rights is grounds for immediate employment termination.

Q **How am I protected from discrimination?** You have the right to be treated fairly and equally. Health Plans may not discriminate against you due to age, sex, religion, race or ethnic origin, disability, occupational status or any other characteristics protected by law.

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You have the right to receive impartial treatment. You have the right to receive all treatment that is a covered benefit and that is determined by the Health Plan to be medically necessary regardless of your age, cultural background, disability, financial status, gender, national origin, occupational status, race, religion, sexual orientation, or membership in other protected groups.

Q **If I refuse treatment, will it affect my future treatment?** If you refuse to be treated for any condition, your Health Plan must tell you what effect your decision will have on future coverage.

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This Health Plan does not restrict your right to refuse treatment. You may refuse treatment at your discretion and it will not affect your access to future treatment, your coverage, or payment for services.

Q **How does the health plan pay providers?** Your Health Plan must tell you about the kinds of financial arrangements it has with providers.

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This Health Plan may include a capitated reimbursement arrangement or other similar risk sharing arrangement, and other financial arrangements with a provider.

Q **How is my health insurance coverage renewed or canceled?**

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This Health Plan renews automatically on its calendar anniversary unless you or your employer chooses another plan. Coverage may be canceled if the membership premiums are not paid, if we discontinue the product, if you cease being eligible, or if you commit fraud, behave abusively in a doctor's office, or impair a doctor's ability to work.

Q **If I am covered by two or more Health Plans, what should I do?** If you or a family member are covered by two or more Health Plans, you may have to give information on your coverage to each Health Plan. This helps the Health Plans to arrange payments between the plans when you or a family member receive a service. Here's what this plan will ask you to tell them.

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This Health Plan will ask if you are the main subscriber or a dependent, your marital status, birth date (for you/your spouse), length of time covered; if you are a Medicare beneficiary; and if you are an active or inactive employee. We may also ask for other information needed to coordinate payments.

Health Benefits Required Under Rhode Island Law as of September 2000:
Health Maintenance Organizations (HMOs) and health insurers in Rhode Island are required by State law to provide enrollees with coverage for certain kinds of health care services. These laws do not apply to Medicare, Medicaid, ERISA self-funded plans or supplemental (e.g. Medigap) or single disease (e.g. Cancer coverage) health insurance policies (check with your workplace benefits administrator). These mandated benefits (see summary list in Consumer's Guide to Health Plans in RI) often apply only under certain circumstances, may be limited to participating providers, and are not always covered in full--other conditions and restrictions not mentioned here may apply. For more information about specific mandated benefits, contact your Health Plan representative or the Rhode Island Department of Business Regulation at 401-222-2223.

Covered Services at a Glance:
The information on the following pages shows you what services are covered under this Health Plan. This is only a summary. You may find complete information in the Official Plan Documents or contact the Health Plan Representative listed on the first page.

Single Service Health Plans (example: dental care, vision care) must provide you with standardized and easy-to-understand information about covered services -- including out-of-pocket costs, service limitations and other things you need to know. Single Service Health Plans can do this through general information materials or by using a special insert summary called "Covered Services at a Glance." For more complete information, read the Official Plan Documents or contact a Health Plan Representative. Using this information, you can compare:

- Health Plans
- Out-of-pocket costs
- Limits on services

Health Plan: VantageBlue Select

COVERED SERVICES AT-A-GLANCE

Annual Deductible: In-Network: Indiv-$0/Family-$0 Out-of-Network: Indiv-$0/Family-$0

Type of Service (Not All Services are Listed) Call plan or check Official Plan Documents for details	Is Prior Authorization Required (Yes/No)	What Out-of –Pocket Expenses Will I Have to Pay?	What Other Limitations Apply?	If I Choose a Non-Participating Provider Will the Service be Covered?
Ambulance (includes municipal, air, and water)	No.	$50 - $300 copayment.	Air/water limited to maximum benefit payment of $3,000 per occurrence.	Yes.
Chiropractic Treatment	No, but it's recommended for provider network access.	$40 - $120 copayment per visit.	Limited to 20 visits or treatments per contract year per member.	No, the service is not covered.
Dental Care	No, but it's recommended for provider network access.	0% - 50% coinsurance.	Dental Care is covered for dependents 19 and under.	Dental Care is covered for emergency room services and for dependents 19 and under.
Diagnostic X-rays, Imaging and Laboratory Tests	No, but it's recommended for provider network access and for medical necessity for certain services.	$20 - $750 copayment.	Routine Mammograms, Pap Smear, and PSA test and other preventive services are covered based on guidelines per PPACA.	No, the service is not covered.
Emergency Services	No.	$400 copayment per hospital emergency room visit.	Life-threatening emergencies only. Copayment applies to the hospital emergency room only. Coverage for other professional services is based on the type of service rendered.	Yes.
Experimental Treatments	No, but it's recommended for provider network access and for medical necessity.	Coverage varies based on type of service. (See limitations)	Limited coverage for experimental cancer treatment as defined by Rhode Island General Laws.	Coverage varies based on type of service. (See limitations)
Eye Care	No, but it's recommended for provider network access.	For members age 19 and older a $0 - $120 copayment. For members under the age of 19 a 0% coinsurance.	Limited to one routine eye exam per contract year. No eyewear coverage for adults.	No, the service is not covered.
Foot Care	No, but it's recommended for provider network access.	See Physician's Office Visits and Surgery, Outpatient.	Limited to surgery and treatment of the foot. Routine foot care is not covered.	See Physician's Office Visits and Surgery, Outpatient.
Health Education & Wellness	No, but it's recommended for provider network access.	$0 - $1,950 copayment or 0% - 20% coinsurance per visit.	Preventive services are covered based on guidelines per PPACA.	No, the service is not covered.

Health Plan: VantageBlue Select

COVERED SERVICES AT-A-GLANCE

Annual Deductible:	In-Network:	Indiv-$0/Family-$0	Out-of-Network:	Indiv-$0/Family-$0

Type of Service (Not All Services are Listed) Call plan or check Official Plan Documents for details	Is Prior Authorization Required (Yes/No)	What Out-of –Pocket Expenses Will I Have to Pay?	What Other Limitations Apply?	If I Choose a Non-Participating Provider Will the Service be Covered?
Home Health Care	No, but it's recommended for provider network access.	$15 - $45 copayment.	No homemaking services or services by members of household.	No, the service is not covered.
Hospice Care	No.	$0 copayment.	None.	No, the service is not covered.
Hospitalization and Inpatient Services	No, but it's recommended for provider network access and for medical necessity.	$800 - $6,350 copayment.	Semi-private room only.	Only if admitted through the emergency room.
Maternity	No, but it's recommended for provider network access.	$800 - $2,400 copayment.	Covers a minimum inpatient hospital stay of 48 hours for vaginal delivery and 96 hours for cesarean delivery.	Only if admitted through the emergency room.
Medical Equipment and Supplies	No.	20% coinsurance.	Equipment purchase/rental limited. Coverage for hearing aids as defined by Rhode Island General Laws. For other limits call us or refer to Official Plan Documents.	Yes, but only for a limited number of services. Call us or refer to Official Plan Documents for details.
Mental Health, Inpatient	No, but it's recommended for provider network access and for medical necessity.	$800 - $2,400 copayment.	Semi-private room only.	Only if admitted through the emergency room.
Mental Health, Outpatient	No, but it's recommended for provider network access.	$15 - $120 copayment per visit.		No, the service is not covered.
Nursing Home Care	No, but it's recommended for provider network access and for medical necessity.	$400 - $1,200 copayment.	Coverage is provided for skilled care in a Nursing Facility only.	No, the service is not covered.

Health Plan: VantageBlue Select

COVERED SERVICES AT-A-GLANCE

Annual Deductible: In-Network: Indiv-$0/Family-$0 Out-of-Network: Indiv-$0/Family-$0

Type of Service (Not All Services are Listed) Call plan or check Official Plan Documents for details	Is Prior Authorization Required (Yes/No)	What Out-of –Pocket Expenses Will I Have to Pay?	What Other Limitations Apply?	If I Choose a Non-Participating Provider Will the Service be Covered?
Physician Office Visits	No, but it's recommended for provider network access.	$0 - $120 copayment per visit.	Pediatric and adult well exams are covered. For other limits, call us or refer to Official Plan Documents.	No, the service is not covered
Prescription Drugs/Devices	Yes.	$10 - $187.50 copayment or 0% - 50% coinsurance.	Coverage is for prescription drugs purchased at a pharmacy. For other limits, call us or refer to Official Plan Documents.	No, for generic, preferred brand and non-preferred brand prescription drugs. Yes, at 50% coinsurance for certain specialty prescription drugs. In addition the difference between the allowable charge and the retail cost of drug may apply.
Rehabilitation (PT/OT/Speech Therapy)	No	$40 - $120 copayment.	.	No, the service is not covered
Substance Abuse, Inpatient	No, but it's recommended for provider network access and for medical necessity.	$800 - $2,400 copayment		Only if admitted through the emergency room.
Substance Abuse, Outpatient	No, but it's recommended for provider network access.	$30 - $90 copayment per visit.		No, the service is not covered.
Surgery, Outpatient	No, but it's recommended for provider network access.	$15 - $120 copayment.	Coverage for multiple, diagnostic, and assistant surgery is limited. For other limits, call us or refer to Official Plan Documents.	No, the service is not covered.
Second Opinion	No, but it's recommended for provider network access.	See Physician Office Visits.	None.	See Physician Office Visits.