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

HEALTHMATE for HSA DIRECT

BLUE CROSS & BLUE SHIELD of RHODE ISLAND
January 1, 2012

Consumer Disclosure

Safe and Healthy Lives in Safe and Healthy Communities

Consumer Disclosure

CONSUMER'S RIGHT TO KNOW ABOUT HEALTH PLANS
HealthMate for HSA Direct

Effective Date of Disclosure: January 1, 2012

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.healthri.org/.

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, Division of Health Services 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

From outside RI: 1-800-639-2227; From inside RI: 401-459-5000; Fax: 401-459-2006; TDD1-888-252-5051; 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 (i.e., medical records, reports) to determine if services :

- are medically necessary, appropriate and effective;
- are not primarily for the convenience of the member or the member's family;
- appropriate with regard to generally accepted standards of medical practice;
- the most appropriate 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 one hundred and eighty (180) days of receipt of the determination. We will review your appeal and respond to you within fifteen (15) days of receipt of all necessary information. If your appeal is denied, you may request an external appeal. An external appeal is performed by an agency that is not affiliated with us.

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 a broad network of participating hospitals, primary care doctors, and specialists and receive coverage for eligible services less any deductibles and/or copayments. Members may seek care without referral from providers outside the network and receive coverage for eligible services at a reduced percentage of the allowable charge less any deductible, coinsurance, and/or copayments.

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 Plan renews automatically on April 1st of each calendar year as long as the membership fees are paid. Your coverage may be canceled on the date membership fees are not paid, the first day of the month following that month in which you cease to be an eligible person, the first day of the month following that month in which you are no longer a Rhode Island resident, the date you commit fraud as determined by us, the date you abuse or disregard provider protocols and policies as determined by us, or if we cease to offer this type of coverage.

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; if you are an active or inactive employee; and if a covered dependent is a student. 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: HealthMate for HSA

COVERED SERVICES AT-A-GLANCE

Annual Deductible: In-Network: Indiv-$3,000-5,000/Family-$6,000-10,000, Out-of-Network: Indiv-$3

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.	The deductible.	Air/water limited to maximum benefit payment of $3,000 per occurrence.	Yes, after deductible at 60% of allowable charge.
Chiropractic Treatment	No.	The deductible.	Limited to 12 visits or treatments per calendar year per member.	Yes, after deductible at 60% of allowable charge per visit.
Dental Care	Not Covered.	Not Covered.	Dental Care not covered.	Not Covered.
Diagnostic X-rays, Imaging and Laboratory Tests	No, but it's recommended for certain services.	The deductible. The deductible does not apply to preventive services.	Routine Mammograms, Pap Smear, and PSA test and other preventive services are covered based on guidelines per PPACA.	Yes, after deductible at 60% of allowable charge.
Emergency Services	No.	The deductible.	Life-threatening emergencies only.	Yes, after deductible at 60% of allowable charge per emergency room visit.
Experimental Treatments	No, but it's recommended.	The deductible. (See limitations)	Limited coverage for experimental cancer treatment as defined by Rhode Island General Laws.	Yes, after deductible at 60% of allowable charge. (See limitations)
Eye Care	No.	See Physician's Office Visits and Surgery, Outpatient.	Limited to one routine eye exam per calendar year. No coverage for eyewear.	See Physician's Office Visits and Surgery, Outpatient.
Foot Care	No.	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.	The deductible.		Yes, after deductible at 60% of allowable charge per visit.

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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.	The deductible.	No homemaking services or services by members of household.	Yes, after deductible at 60% of allowable charge.
Hospice Care	No.	The deductible.	None.	Yes, after deductible at 60% of allowable charge.
Hospitalization and Inpatient Services	No, but it's recommended.	The deductible.	Semi-private room only.	Yes, after deductible at 60% of allowable charge.
Maternity	No.	The deductible.	Covers a minimum inpatient hospital stay of 48 hours for vaginal delivery and 96 hours for cesarean delivery.	Yes, after deductible at 60% of allowable charge.
Medical Equipment and Supplies	No, but it's recommended for certain services.	The deductible.	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, after deductible at 60% of allowable charge.
Mental Health, Inpatient	No, but it's recommended.	The deductible.	Semi-private room only.	Yes, after deductible at 60% of allowable charge.
Mental Health, Outpatient	No.	The deductible.		Yes, after deductible at 60% of allowable charge per visit.
Nursing Home Care	No, but it's recommended.	The deductible.	Coverage is provided for skilled care in a Nursing Facility only.	Yes, after deductible at 60% of allowable charge.

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COVERED SERVICES AT-A-GLANCE

Annual Deductible: In-Network: Indiv-$3,000-5,000/Family-$6,000-10,000, Out-of-Network: Indiv-$3

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.	The deductible. The deductible does not apply to covered adult preventive office visits/ immunizations and covered pediatric well child office visits /immunizations.	Pediatric well-child exams are covered in accordance with the guidelines established by the American Pediatric Academy. For other limits, call us or refer to Official Plan Documents.	Yes, after deductible at 60% of allowable charge per visit.
Prescription Drugs/Devices	No.	$7 to $50 copayment after deductible for generic, preferred brand, and non-preferred brand prescription drugs (Tier 1 to 3). $75 copayment for specialty prescription drugs (Tier 4).	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% of allowable charge for specialty prescription drugs.
Rehabilitation (PT/OT/Speech Therapy)	No, but it's recommended for speech therapy.	The deductible.	Early Intervention Services are limited to $5000 for a child residing in RI, from birth to 36 months, per calendar year. The Rhode Island Department of Human Services must certify the provider.	Yes, after deductible at 60% of allowable charge.
Substance Abuse, Inpatient	No, but it's recommended.	The deductible.		Yes, after deductible at 60% of allowable charge.
Substance Abuse, Outpatient	No.	The deductible.		Yes, after deductible at 60% of allowable charge per visit.
Surgery, Outpatient	No.	The deductible.	Coverage for multiple, diagnostic, and assistant surgery is limited. For other limits, call us or refer to Official Plan Documents.	Yes, after deductible at 60% of allowable charge.
Second Opinion	No.	See Physician Office Visits.	None.	See Physician Office Visits.