Member Handbook

It takes a team

Blue Cross Blue Shield of Rhode Island

Get the Most From Your Healthcare Coverage

In this member handbook, you'll find information about the many health benefits, programs, and services available to you as a Blue Cross & Blue Shield of Rhode Island (BCBSRI or Blue Cross) member. We offer many different plans, so please see your subscriber agreement/benefit booklet for specific benefits. If you have questions about your benefits or anything in this handbook, we're happy to help. Simply call customer service at the number on the back of your member ID card.

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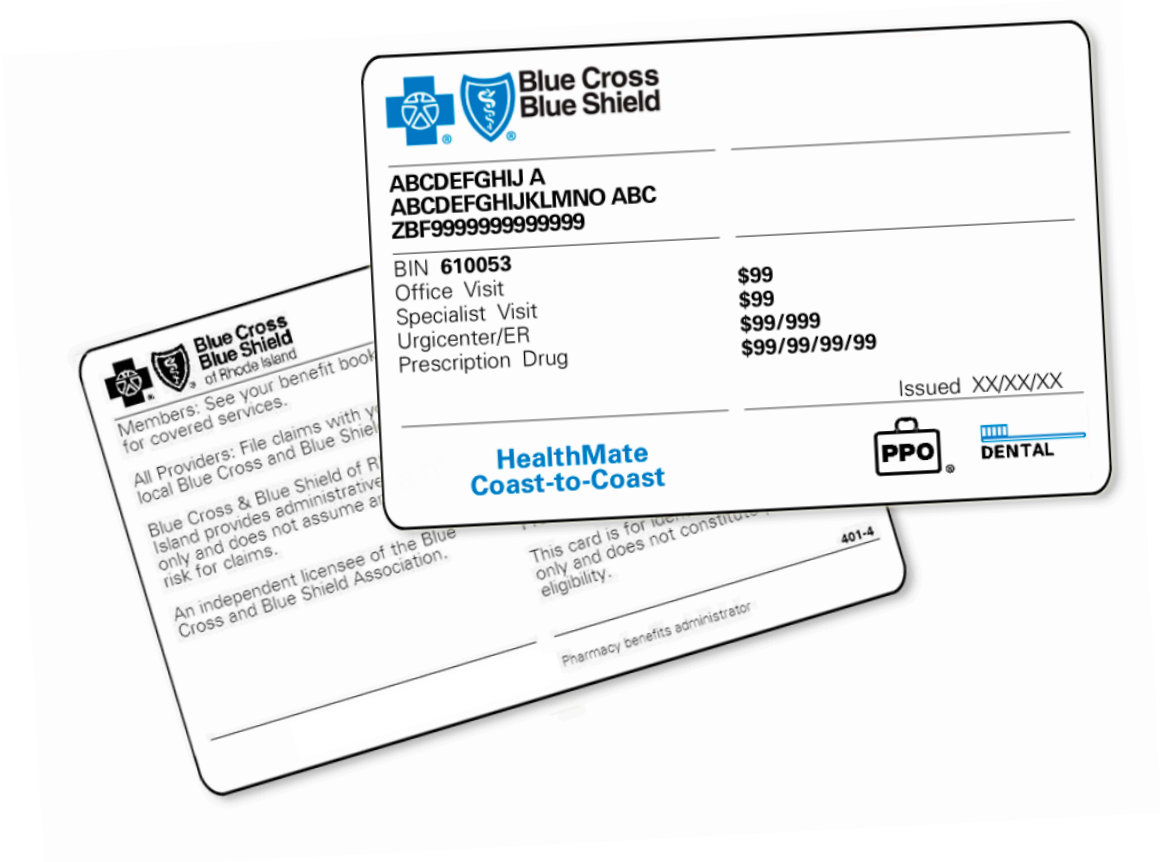
Please remember that this handbook is not a contract. The benefit details of your plan are described in your subscriber agreement/benefit booklet. When you need specific information about your plan, please refer to your subscriber agreement/benefit booklet or call customer service at the number on the back of your member ID card.

Your member ID card

It's one of the most important cards in your wallet. Your Blue Cross member ID card provides important information about your benefits, so please keep it with you at all times.

Helpful do's and don'ts

- Do give your card to your provider whenever you receive care.
- Do check your card, and make sure all the information on it is correct. If you spot an error, please call customer service so we can issue a new card.
- Don't let anyone else use your card. Family members have their own cards for when they need care.
- Do hold on to your children's cards so they don't get lost. Show the card when you bring children in for medical care.
- Do call customer service immediately if you lose your card. This will help us mail your replacement card sooner. To be on the safe side, make a photocopy of your card, and keep it with other important information about your healthcare or health plan. If you lose your card, you'll be able to report your member ID number.



Many reasons to visit bcbsri.com

On our website, it's now easier to find what you need, including the self-service options that you've been asking for. And this is just the beginning—you'll be seeing more improvements to our website in the future. Log in to your secure member site today to access the many time-saving resources available through **bcbsri.com**. Once logged in, you can:

- Look up your benefits and deductibles
- View and print claims for your records
- Find a network doctor and print out directions to the office
- Use our cost calculator tool to compare costs for the same service at different providers and hospitals
- Request a new Blue Cross member ID card. You can even print a paper confirmation to use until your new card arrives
- Send a secure message to customer service
- Get personalized tips by taking a personal health assessment
- Track your physical activity and nutrition
- Explore the trusted articles and tools in our Health Center

See page 10 for more information about the health and wellness resources available on **bcbsri.com**.

Make the most of your drug coverage—online!

If you have prescription drug coverage through BCBSRI, you can find everything you need to manage and maximize your coverage by logging in to your member page on **bcbsri.com**. Just click on Pharmacy on the left side of the page to:

- View your prescription drug history
- Order drugs through the mail
- Find quantity limits, step therapy, and other information on restrictions
- View the covered drug list (formulary)
- Learn about how you can save money with generic drugs
- Start the medical exception process
- Determine a drug's common side effects, significant risks, and potential interactions
- Find the copayment of any drug to be filled at a retail pharmacy
- Find a pharmacy and get door-to-door directions
- Get the most frequently requested forms and documents
- Learn which medications require additional paperwork from your provider (specialty drugs)

If you purchase plans directly from Blue Cross

Use our interactive plan selection tool to help you choose the best plan for your needs. This tool lets you compare plans side-by-side and find coverage with the right blend of benefits and features you want. You can also apply online!

Visit today!

If you've never been to **bcbsri.com**, now's the time to check it out—and don't forget to register for access to your secure member site!

Your primary care physician: The doctor who knows you best

Quality healthcare begins with partnerships between you and your doctors—and most important is your partnership with your primary care physician (PCP). A PCP is a family practitioner, internist, or pediatrician who provides care when you are sick and when you are healthy (for regular check-ups and preventive care such as flu shots and blood pressure screenings).

How to find a doctor

If you need help finding a PCP, another doctor such as a mental health and substance abuse provider, or a hospital/facility, you can use the Find a Doctor tool on **bcbsri.com** or call customer service at the number on the back of your member ID card. You can get information such as board certification status, languages spoken by the doctor, and whether the office is wheelchair accessible. You can even print out directions to the doctor's office. Please note: If you have a question about a doctor that customer service can't answer right away, they will get back to you with an answer. This includes questions on education, training, residency completed, board certification, and specialty.

Tips for partnering with your PCP

Your PCP needs to get to know your medical history and individual needs. The more information your doctor has, the easier it is to give you the care you need. Be sure to make an appointment for a routine physical, and discuss any health-care questions or concerns you have. If you are new to a practice you should expect to be seen within 30 days from the time of your call.

When making an appointment

- Always call your PCP's office directly to make an appointment. Be sure to have your member ID card handy and to record the date and time of the appointment. You may want to have a calendar close by so you can tell if a particular time or date is convenient.
- Call well in advance of your desired appointment date to schedule a convenient time. Depending on the kind of appointment you are making (a routine or sick visit), the time it takes to get an appointment could vary.
- Identify yourself as a BCBSRI member.
- Say why you would like an appointment—whether you want a routine exam or need to speak with the doctor about a particular problem. If you need an emergency appointment, say so right away.
- Leave a phone number where your PCP can reach you to confirm, cancel, or postpone an appointment.
- Be sure to call your PCP's office if you cannot keep an appointment. Most offices require you to cancel at least 24 hours in advance, but check your doctor's policy. Your best bet is to cancel an appointment as soon as you know you can't keep it. If you don't cancel your appointment as required by your PCP's policy, you may be charged for that appointment time.

Talking to your PCP

- Bring a list of questions or issues that concern you. Have you had troubling symptoms? Questions about medications? Write them down, and share them with your doctor. In the days before your appointment, make a list of questions. Bring the questions to your appointment, and take notes during your visit.
- Bring a list of your medications, their doses, and how often you take them. Include prescriptions, over-the-counter drugs, herbal medicines, vitamins, and nutrition/diet aids.
- Make a list of any healthcare providers you've seen since your last appointment as well as any medical tests you've had.
- Listen. If you do not understand something, let your doctor know. It is important that you are clear about all parts of your care and treatment.

Getting care after hours

If you need care after hours or when your PCP is not available, you should still call your PCP's office. PCPs make arrangements for continuous coverage, 24 hours a day, seven days a week so you can get the care you need even if they're not personally available. If you need to leave a message with an answering service, you should expect a call back within one hour.

Important note: If you are having a medical emergency, call 911, not your doctor! See page 8 for information on emergency care.

Great care on call: 24/7 nurse care line

Now you can talk to a nurse—any time of the day or night—with our 24/7 nurse care line. This service is available to you at no cost, and it is available in many languages. This service is also TDD accessible. Just call **1-844-50-NURSE (1-844-506-8773)** with questions about your family's health, including:

- Colds, the flu, and other illnesses
- Minor injuries such as sprains and cuts
- Headaches
- Medications and side effects
- Health problems such as diabetes or asthma
- And much more

Other providers you may need

If you need care beyond what your PCP provides, you may need to see a doctor/healthcare provider who has a particular medical specialty, such as a cardiologist for a heart condition or a mental health counselor for anxiety. Depending on your plan, you may need a referral from your PCP to see a specialist. But even if you don't need a referral, it's a good idea to ask your PCP for a recommendation about which doctor to see. He or she may even be able to set up an appointment for you.

Be sure to give the specialist your PCP's name and contact information so they can share information about your health and make sure that your care is coordinated.

If you need help finding a doctor or hospital/facility in our network, please use the Find a Doctor tool on **bcbsri.com** or call customer service at the number on the back of your member ID card.

Patient-centered medical homes: Extra care when you need it

If you are looking for a new PCP or want an extra level of care, consider a doctor who is part of a patient-centered medical home (PCMH). At a PCMH, you'll receive care from a team led by a PCP. Your team includes a nurse case manager dedicated to Blue Cross members and may also include a mental health and substance abuse provider, a pharmacist, and specialists. They'll help you create a personalized care plan that keeps you focused on your health goals.

9 Advantages of a PCMH

1. **Access to a comprehensive team of care providers**

2. **Extended office hours**

3. **Care that is coordinated with other providers**

4. **Appointment and medication reminders**

5. **Personalized support for health conditions**

6. **Help transitioning from the hospital to home**

7. **Expanded community resources**

8. **Use of electronic health records**

9. **Proactive monitoring with test results**

Join a PCMH

To find a provider who is part of a PCMH, use our Find a Doctor search tool on ***bcbsri.com*** *or call customer service at the number on the back of your member ID card.*

Emergency care and urgent care

It's important to know the difference between emergency care and urgent care and how to get the right care when you need it.

Emergency care

What is an emergency?

An emergency is a medical problem that places your health in serious danger. It's an illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm. Such a medical problem is usually life-threatening if you don't get treatment right away.

Examples of emergency care include:

- Chest pain
- Convulsions
- Heart attack
- Loss of consciousness
- Major burns
- Poisoning
- Severe difficulty breathing
- Spinal injury
- Stroke
- Uncontrollable bleeding

What should I do if I have a medical emergency?

When you need emergency care, call 911 or go to the nearest emergency room. It's a good idea to contact your PCP to arrange follow-up care. Refer to your subscriber agreement/benefit booklet for details on your emergency care coverage.

Urgent care

What is urgent care?

Even if you do not have a true emergency, you might still need care within 24 hours. This is called urgent care. Some reasons you might need urgent care include:

- Minor injuries, such as sprains or strains
- Illness such as pink eye, urinary symptoms, prolonged vomiting or diarrhea
- Pain or distress that is moderate in nature but not life threatening

What should I do if I need urgent care?

If you need urgent medical care, it's a good idea to call your PCP first. Remember that you can call your PCP 24 hours a day, seven days a week, whenever you feel you need medical attention. Your PCP should be able to schedule an appointment within 24 hours for urgent care needs. If your PCP cannot see you, then go to an urgent care center or walk-in clinic.

What if I need urgent care away from home?

Blue Cross participates in the BlueCard Program, which enables you to access the BlueCard national network if you need urgent care when away from home. Call customer service to verify your benefits and to find a provider in the local area. You can also call **1-800-810-BLUE (2583)** or visit **bcbsri.com** to access the 24-hour-a-day doctor and hospital finder. With the BlueCard Program, care will be covered as if you received it at home. You will pay the same copayment or deductible that is required when you receive care at home. The doctor will then file the claim for you.

For information about out-of-network coverage, please see page 15.

Medical management

Preauthorization

At Blue Cross, we work with your doctor to ensure that you get the care you need at the right time and in the appropriate setting. For some types of care, it is recommended or required that you get prior approval (preauthorization) from Blue Cross.

Your PCP or specialist may contact us or one of our vendors for preauthorization for some kinds of care. This care includes, but is not limited to, the following:

- Pre-scheduled, elective hospital admissions (such as surgery)
- Speech therapy
- Certain radiology services (including MRI, MRA, CAT scans, and nuclear cardiac imaging)
- Certain prescription drugs

In some cases, we may review your care and decide that it could have taken place in a more appropriate setting or determine that it is not a covered benefit under your plan. If we deny coverage for a service, you may appeal our decision. (See page 18 for details.)

For members with BlueCHiP and BlueCHiP Advance Plans

Some medical services included in your plan require a referral from your primary care physician (PCP). We strongly recommend that you review your plan specific subscriber agreement to determine which services require a referral. If you obtain services that require a referral and you have not received the referral from your PCP, your claim could be denied or could result in a higher cost share.

Reviews

We work with your doctor to ensure that you receive the care that meets your needs. In addition to preauthorization, we sometimes perform a concurrent review (an evaluation of your medical chart at time of care) or a retrospective review (an evaluation of your medical chart after you receive care). These reviews are all part of our Utilization Management Program, which ensures that members are receiving the appropriate care and services in the proper healthcare setting.

Utilization Management Program

All utilization review decisions are based only on appropriateness of care, service, existence of coverage, and setting of the covered service. Please note:

- We do not use financial incentives in conjunction with our Utilization Management Program.
- We do not reward doctors who conduct utilization review for issuing denials of coverage or service.
- We do not offer financial incentives to utilization management decision makers that encourage decisions resulting in underutilization.

To request preauthorization or other utilization management matters, please call the **utilization management department** at **(401) 272-5670** or **1-800-635-2477** (outside of Rhode Island only) during normal business hours: Monday through Friday, 8:00 a.m. to 4:30 p.m. **TTY** (Telecommunications Device for the Deaf) services are available by calling **1-888-252-5051** during normal business hours. If you need interpreter services to discuss utilization managementmatters, please ask one of our representatives about using an interpreter. After hours, if it is a non-urgent matter, you will be directed to leave a brief message with your name and number. Your call will be returned the next business day.

As part of our Utilization Management Program, members have the right to appeal our review decisions (see Medical appeals on page 18). These standards also apply to all medical appeal decisions.

Care Coordination

Care Coordination provides members with access to dedicated BCBSRI health care professionals- nurses, dietitians, behavioral health, and community resources specialists who help members work on their health goals. We start by listening to you, learning your priorities, and collaborating with both you and your providers. We help you follow your treatment plans and work toward improving your health. We work mostly over the phone, but can arrange to meet at community events or at our retail stores located throughout Rhode Island. Care Coordination support can cover many topics including but not limited to how to make the most of your doctor's visits, navigate through the health care system, manage medications or address their potential side effects, better understand new or pre-existing medical conditions, address symptoms of anxiety, depression or substance use, complete preventative screenings, or tackle weight loss.

Care Coordination is a personalized service that is part of your existing benefit and is available at no additional cost to you. Let Care Coordination be the next step in reaching your health goals. For more information, please call **401-459-CARE (2273)** or email **Triage_Group@bcbsri.org**.

Programs to help you be healthy

Many health problems can be prevented by making positive changes to your lifestyle, including exercising regularly, eating a healthy diet, and not smoking. Stay healthy by taking advantage of our wellness programs—in the community, at work, at the doctor's office, and online!

Preventive health program

No matter what your age, prevention is the first step to a healthy life. For adults of all ages, we provide comprehensive resources on appropriate health screenings and vaccinations as well as information on the importance of an annual wellness visit.

Worksite wellness

For worksite clients that offer our Wellness Works™ product, employees can participate in interactive and educational wellness programs at work.

Community wellness

BCBSRI's community wellness programs provide greater healthcare accessibility to all Rhode Islanders—at no cost for participants—by partnering with local community-based agencies. These programs bring many important services to those in need, with a focus on the uninsured, including health screenings, free flu shots, on-site health and wellness programs, health education and workshops, and information about Blue Cross insurance options.

Learn about wellness with bcbsri.com

Health Assessment (HA)

Take this completely confidential online questionnaire to receive a personalized report that rates your health from one to 100! The report also summarizes your health status and risk factors, and provides resources to help you improve your health.

Fitness discount program

Take advantage of our special low rates when you join a local fitness center through this innovative program.

Health Center

Get help making good health decisions by using online interactive tools like the "symptom checker," plus gain access to reliable information on thousands of health conditions, medications, medical tests, and more.

Healthy lifestyle programs

Improve your health and enjoy a better quality of life with video programs to help you lose weight, reduce stress, eat healthier, take care of your back, and stop smoking.

Wellness trackers

Our wellness trackers allow you to track your physical activity and to record your daily food choices. A personalized graph will show you if you're making progress toward your goals. For example, a personalized graph will show you if you're on your way to losing or gaining weight.

Programs to help you manage chronic conditions

If you have a chronic condition such as asthma, coronary heart disease, diabetes, congestive heart failure, and/or chronic obstructive pulmonary disease, we're here to help. We offer tools and information to help you manage your condition and improve your health. You may also be eligible to receive help through our Care Coordination Program.

This voluntary program is available at no cost. Care coordination services may be offered with the programs described below.

Asthma Program
If you or your child has asthma, we offer age-specific information and tools to help control the condition.

Coronary Artery Disease Program
If you were recently identified as having high cholesterol, we'll send you educational information. When you enroll in care coordination, you'll receive information on the basics of heart disease, medications, nutrition, physical activity, and stress. You'll also receive a reminder if you are not taking your cholesterol-lowering medication on a regular basis.

Diabetes Program
You'll receive reminders for important diabetes-related exams and tests and information about diabetes self-care and quitting smoking.

Congestive Heart Failure Program
When you enroll in care coordination, we'll help you manage your condition by sending information on taking care of your heart failure, including eating healthy foods, taking your medications, and monitoring your weight and symptoms.

Chronic Obstructive Pulmonary Disease (COPD) Program
If you have trouble breathing as a result of COPD, you can receive information about caring for your condition.

Depression Program
To help you manage your depression and feel better, you can receive provider referrals, information about depression, and help with managing your medication.

Call us for more information

To learn more about any of these programs, call **(401) 459-5683** or **1-888-725-8500** and leave a message. We review messages on weekdays and will reply within 24 hours, Monday through Friday, 8:15 a.m. to 4:15 p.m.. All members who meet certain criteria—based on doctor referral, claims review, or diagnosis—may be eligible for these programs. Your membership in these programs is voluntary. You may stop taking part in a program at any time by calling us at the numbers above.

Visit Your Blue Store℠

Sometimes you want to talk in person instead of on the phone—especially about important decisions like your health plan. Now that's easier than ever with our convenient store locations in Bristol, Lincoln, and Warwick.

Our local team is happy to help you in English or Spanish. Come by to:

- Ask a question about your plan
- Take a free class
- Make a payment
- And much more

Visit bcbsri.com/yourbluestore to learn more.

Your member rights and responsibilities

As a Blue Cross member, you are a partner in your health—both with your doctor and with Blue Cross. That's why it's important to understand your rights and responsibilities. If you have any questions about the member rights and responsibilities listed below, please call customer service at the number on the back of your member ID card. Our representatives will be happy to explain anything you have questions or concerns about.

If you ever feel that any of your rights as a member have not been recognized, please let us know. On page 18, you'll find a description of our complaints and appeals procedures.

As a Blue Cross member, you have the right to:

- Receive information about Blue Cross, our services, our practitioners and providers, and your member rights and responsibilities.
- Be treated with respect and with recognition of your dignity and right to privacy.
- Receive a second opinion at the applicable copayment, coinsurance, and/or deductible concerning a proposed surgical procedure.
- Participate with practitioners in making decisions about your healthcare. This includes receiving information concerning your diagnosis, treatment, and prognosis in terms that can be reasonably understood. In the event your doctor considers access to such information inadvisable by reason of medical condition, age, and/or lack of decision-making capacity, the information will be given to an appropriate person on your behalf.
- Have a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Know about resources such as customer service representatives, complaints and appeals processes, and language interpretation resources that can help you answer questions and resolve problems and complaints.
- Voice complaints or file appeals about Blue Cross or the medical care you receive.
- Make recommendations regarding Blue Cross's rights and responsibilities policies for members.
- Receive impartial (fair) access to treatment. This means that you have the right to all medically indicated treatment that is a covered benefit, regardless of your race, religion, sex, sexual orientation, gender identity, national origin, cultural background, disability, or financial status.
- Receive medical care and services provided by health professionals who meet the professional standards established by Blue Cross.
- Select a PCP.

Customer service

Our customer service representatives are here to help with any questions or issues you may have. Please call customer service at the number on the back of your member ID card. Customer service representatives are available Monday through Friday, 8:00 a.m.– 8:00 p.m., as well as on Saturday and Sunday, 8:00 a.m. to noon. An automated system is available outside of these hours.

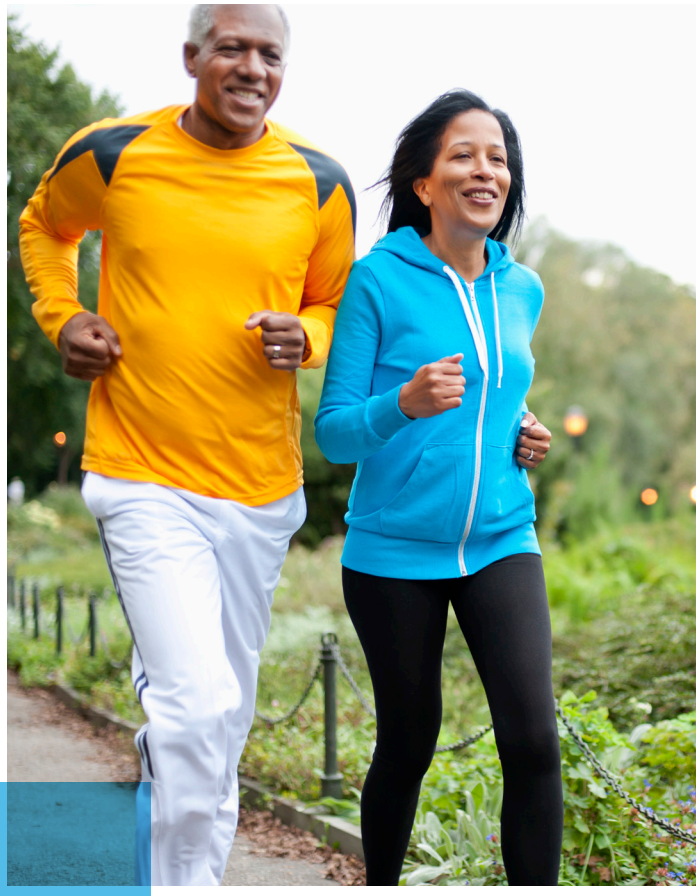
If you need interpreter services

We have Spanish-speaking customer service representatives, and we have access to TransPerfect, Inc., which provides interpreter services in numerous languages. This includes languages originating from Africa, Asia, Europe, the Middle East, South America, the Caribbean, and the Pacific Islands. We can also assist your provider in obtaining in-office sign language services. For more information on these services,please give us a call at 1-800-639-2227.

As a Blue Cross member, you have the responsibility to:

- Fulfill financial obligations. You are responsible for paying applicable premiums, deductibles, copayments, coinsurance, and other fees as outlined in your plan documents.
- Know the extent and limitations of your healthcare benefits, as described in your subscriber agreement/benefit booklet.
- Understand your health problems and participate in developing mutually agreed upon treatment goals. This includes certain circumstances in which your doctor may recommend a course of treatment that is not covered by your plan. Ask your doctor to clearly explain your treatment plan and what is expected of you until you fully understand.
- Schedule regular preventive care appointments with your PCP. This includes routine physical exams, health screenings, and immunizations.
- Give accurate and complete information (to the extent possible) about your present and past medical condition that Blue Cross and your healthcare provider need in order to provide care. You should report unexpected changes in your condition to your healthcare provider.
- Follow the treatment plan and instructions for care that you have agreed to with your healthcare provider. If you feel that you cannot follow through with your treatment, tell your healthcare provider.
- Present your member ID card whenever you seek care and use the card only as appropriate. Make sure that other people do not use your member ID card.
- Keep appointments. Know your provider's appointment cancellation policy, and promptly cancel any appointment that you do not need or cannot keep.
- Be considerate of healthcare professionals, staff, and other patients.
- Seek care through your PCP whenever possible (except in emergencies).

It's important to recognize how your lifestyle affects your health. Your health depends not just on care provided by doctors, but also on the decisions you make in your daily life, such as smoking or not getting care recommended by your doctor.



Your financial responsibilities

In addition to your general rights and responsibilities, you also have financial responsibilities as a Blue Cross member.

Premiums

If you buy your health plan directly from Blue Cross, you are responsible for paying your premiums to us. If you have a group health plan, your employer may ask you to share in premium costs.

Deductible

Under your plan, some of your health services may be covered in full, while others require a deductible. A deductible is the amount a member pays before the health plan starts to pay for certain medical bills. It resets every calendar year or plan year. You must pay any applicable deductibles once the claim for your service is processed.

Coinsurance

Under your plan, some of your health services may be covered in full, while others require coinsurance. Coinsurance is the percentage of a covered service that you are responsible for paying. (For example, if your plan has 20% coinsurance for a healthcare service, you would pay 20% of the cost and your plan would pay the remaining 80%.) You must pay any applicable coinsurance once the claim for your service is processed.

Copayments

Under your plan, some of your health services may be covered in full, while others require a copayment. A copayment is a fixed dollar amount you are required to pay for covered services at the time you receive care. (For example, you may have a $20 copayment for doctor's office visits.) You have a responsibility to make any applicable copayments at the time of treatment.

How claims are paid

Here's a quick overview of how members' healthcare services are paid:

1. When you go to a network doctor, he or she submits a claim to Blue Cross for payment. The claim includes detailed information about:
   - What services were provided
   - Who provided the services
   - When the services were received
2. Blue Cross pays your doctor our share of the claim. Depending on your plan, we may pay all of the claim or part of the claim. You may owe part of the claim as a **copayment, coinsurance**, or **deductible**.
   - *If you have a copayment*, your doctor will probably ask you to pay a certain amount (such as $20) at the time of your visit.
   - *If you have coinsurance or a deductible*, the amount that you pay will change based on the cost of the service and whether or not you have met your deductible. So the doctor may wait to see what Blue Cross pays before sending you a bill. We will also send you a Healthcare Services Summary, which tells you how much the doctor was paid and how much you owe. The Healthcare Services Summary is not a bill. You should wait to get a bill from your doctor before paying your share.

If you receive care from a non-network provider

If your plan covers out of network services, and you choose to receive care from a provider outside of our network, you are responsible for paying all charges up front and submitting a claim to Blue Cross for consideration of payment. For healthcare services covered under your plan, we reimburse you or the non-network provider up to our

allowance, which is the most that we pay for a covered service.

If your plan does not cover out of network services, services would only be covered in emergency and urgent situations. For all other services we strongly recommend that you call customer service prior to accessing these services. The customer service number is located on the back of your member ID card. If you do not call, you may be liable for all charges.

How to submit for reimbursement

Ask the non-network provider who treated you for an itemized statement (including diagnosis and procedures) and a receipt. The receipt should include the following information: diagnosis code/description, health service code/CPT code/description of service or item, charge for each service, patient ID number, patient name, provider name, provider address, the provider's letterhead/logo, provider tax ID number, and specific date(s) of service. Submit clear black-and-white copies of these items to Blue Cross with a letter explaining your request. Be sure your letter includes your name, address, and member ID number. Send your letter to:

Blue Cross & Blue Shield of Rhode Island
Attn: Claims Department
500 Exchange Street
Providence, RI 02903

Remember, if you receive medical services that are not covered by your plan, you are responsible for those costs. If you have any questions, call customer service at the number on the back of your member ID card.

If you have more than one health plan

If you, your spouse, or your children are covered by a Blue Cross plan and by another group health plan (your spouse's healthcare plan, for example), you must follow the coordination of benefits rule. This rule ensures that you get the most from your coverages and that healthcare services are not paid for twice.

How coordination of benefits works

The coordination of benefits rule helps decide which plan provides primary benefits and which provides secondary benefits. Generally, the plan that covers you as a subscriber (such as a plan through your employer) is primary and pays first, and the plan that covers you as a dependent is secondary (such as a plan through your spouse's employer).

The primary plan provides benefits (healthcare services and reimbursements) according to your contract. The secondary plan also provides benefits, but may take into account any benefits you have already received from your primary plan. This avoids overpayments for healthcare services.

Healthcare plans generally follow the same rules to decide which plan is primary for a member and which is secondary. Blue Cross follows the rules as adopted by Rhode Island regulations.

If your children are dependent members under both your Blue Cross plan and your spouse's plan

The plan of the parent whose birthday (month and day) comes earlier in the year is primary. If you are divorced or separated, the plan of the custodial parent is primary, the plan of the spouse of the custodial parent is secondary, and the plan of the noncustodial parent is last, unless different arrangements have been stated in the divorce decree.

If none of the above rules establishes primary/secondary responsibility of the plan, then the plan that has been in force longest is primary.

Your responsibilities regarding coordination of benefits

You must tell Blue Cross that you have other coverage and cooperate with us in our administration of coordination of benefits with your other plan. This includes agreeing to our right to receive and release information about benefits provided to you. While you and/or your dependents may receive benefits under both the primary and secondary plans, you still must pay any deductibles, copayments, or coinsurance that apply.

If you are hurt in an accident

If you are in an accident covered by another insurer (auto insurance, for example) or caused by someone else, your plan will cover the cost of your care in accordance with your covered benefits. We will have the right to seek payment from other individuals, organizations, or companies that are shown to be legally responsible for your injuries or otherwise required to compensate you for your injuries. The legal term for this process is subrogation.

Your responsibilities regarding subrogation

You must tell us that you have been in an accident. Examples include auto accidents, slips and falls, accidents resulting from the use of a specific product, and workers' compensation claims. You must work with us in our subrogation efforts, including agreeing to our right to get and release information about benefits provided to you.

For details about coordination of benefits, subrogation, or any of your financial responsibilities under your plan, please see your subscriber agreement/benefit booklet or call customer service at the number on the back of your member ID card.

Limitations and exclusions

There are certain limitations and exclusions to your Blue Cross policy. For example, Blue Cross plans do not cover cosmetic surgery, long-term care, custodial care, weight-loss programs, and routine foot care (unless there are systemic conditions). For a complete list of covered benefits and exclusions, please refer to your subscriber agreement/benefit booklet or call customer service at the number on the back of your member ID card.

Evaluating new technologies

Our medical directors and the medical policy department continually research medical technologies and treatments to decide if they should be covered. We also follow guidelines established by the Blue Cross and Blue Shield Association and national guidelines.

Complaints and appeals

The Grievances and Appeals Unit (GAU) provides a thorough, timely, and unbiased review of complaints and administrative and medical appeals. The purpose of this process is to assure that benefits are administered equitably according to member contracts, regulatory mandates, accrediting standards, and Blue Cross policies. This process will ensure that objective, equitable outcomes are achieved.

Complaints and administrative appeals

A **complaint** is a verbal (spoken) or written communication explaining that you are unhappy with any part of our operations or the quality of care you received. A complaint is not an appeal, an inquiry, or a problem of misinformation that is fixed right away by clearing up the misunderstanding or supplying the appropriate information to your satisfaction.

An **administrative appeal** is an oral or written request for BCBSRI to reconsider a full or partial administrative denial or a request for BCBSRI to reconsider an adverse decision that affects the member's ability to receive benefit coverage, access to care, access to services, or any unresolved member complaints.

We will let you know we received your complaint or administrative appeal in writing or by phone within 10 business days. The GAU will conduct a complete review of your complaint or administrative appeal and respond in the time frames below.

Level 1 complaint

We will respond to your Level 1 complaint in writing within 30 business days of the date we receive your complaint. The letter with our decision will provide you with the reason for our response and information on the next steps available to you, if any, if you are not satisfied with the outcome (result) of the complaint.

Level 2 complaint (when applicable)

A Level 2 complaint may be submitted only when you have been offered a second level of complaint in the letter that included your Level 1 decision. The GAU will conduct a complete review of your Level 2 complaint and respond to you in writing within 30 business days. The letter with our decision will provide you with the reason for our response and information on the next steps if you are not satisfied with the outcome of the complaint.

Administrative appeal

If you wish to file an administrative appeal, you must do so within 180 days of receiving a denial of benefits. We'll respond to your administrative appeal in writing within 60 calendar days of receiving it. The letter with our decision will provide information about why that decision was made.

Blue Cross does not offer a Level 2 administrative appeal. You may notify the State of Rhode Island Department of Health regarding your concerns. Please refer to the judicial review section on page 19 for additional information.

Medical appeals

A **medical appeal** is a verbal or written request for us to reconsider a full or partial denial of payment for services that we decided were:

- Not medically necessary, or
- Available in our participating provider network.

If we deny payment for a service for medical reasons, you'll receive the denial in writing. The written denial you receive from us will explain the reason for the denial and provide specific instructions for the medical appeals process.

Level 1 review

You may request a Level 1 review of any matter that is subject to medical appeal by making a request (preferably in writing) for such a review to Blue Cross within 180 calendar days of the initial decision letter.

You will receive written notification of the decision on a Level 1 pre-service review within 15 calendar days of receipt of the medical appeal request. If you are requesting reconsideration (Level 1 review) of a service that was denied after you already obtained the service (retrospectively), you will receive written notification of our decision within 15 business days of our receipt of the appeal.

Level 2 review

Applicable only to members with employer group coverage

You may request a Level 2 appeal review (preferably in writing) if our denial was upheld during the Level 1 review process. Your Level 2 appeal review will be reviewed by a provider in the same specialty as your treating provider. You must submit your request for a Level 2 appeal review within 180 calendar days of the date of the reconsideration decision letter. Upon request for a Level 2 review, Blue Cross will provide you with the opportunity to inspect the medical file and add information to the file.

You will receive written notification of the decision on a Level 2 pre-service review within 15 calendar days of the appeal request. If the service you are requesting review of was denied after you already obtained the service (retrospectively), you will receive written notification of our decision within 15 business days of our receipt of the appeal request.

Note: You may request an expedited (faster) review of denied services if the circumstances are urgent or if you are in an inpatient setting. You or your doctor must call the GAU at (401) 459-5784 or 1-800-528-4141 or fax your request. An expedited decision will be made within two business days following receipt of the request, or sooner if the urgent nature of the circumstances requires a more immediate response. Members in urgent situations and while receiving an ongoing course of treatment may proceed with expedited external review at the same time as the internal appeals process.

External appeal

Available to members with employer group coverage after the second level appeal denial

Available to members with individual coverage after the first level appeal denial

If you remain dissatisfied with the decision of Blue Cross's internal review (Level 1 and Level 2) processes, you may request an external review by an outside review agency. An external appeal is a complete re-examination of your case by an independent review organization (IRO). For members covered by group health plans, this external appeal is a voluntary level of appeal. This means that you may choose to participate in this level of appeal, or you may file suit in an appropriate court of law (see judicial review).

To request an external review, you must submit your request in writing to Blue Cross within four months of your receipt of the medical appeal denial notification. Members are not required to bear any costs when requesting a case be sent for external review to an IRO. Blue Cross will forward your letter and the entire case file to the IRO within five business days, or two business days for an expedited appeal. Upon receipt of the necessary information, the IRO will notify you of the result of your appeal within 10 business days, or two business days for an expedited appeal. If the IRO overturns our decision, we will authorize or pay for the services in question.

Judicial Review

If you are dissatisfied with the final decision of the IRO, you are entitled to a final review (a judicial review). This review will take place in an appropriate court of law.

For members covered by group health plans, you have the right to bring a civil action following an adverse benefit determination on review pursuant to section 502(a) of the Employee Retirement Income Security Act of 1974. For these members, you may bring such action either after your appeal is decided for administrative appeals, or prior to the external review level for medical appeals.

Note: At any time, you may request copies of your case file (free of charge) by contacting us at the telephone number(s) listed on page 19 or in your decision letter.

How to file any complaint or appeal

If you're unhappy with any aspect of our operations, the quality of care you have received, or you have a request for us to reconsider a full or partial denial of services or benefits, please call customer service at the number on the back of your member ID card. A customer service representative will log your inquiry and try to resolve your concern. If your concern is not resolved to your satisfaction, you may file a complaint or appeal verbally with the customer service representative.

You may also file a complaint or appeal in writing. To do so, you must provide all of the information below:

- Your name, address, and member ID number
- A summary of the complaint or appeal, any previous contact with Blue Cross, and a brief description of the relief or solution you are seeking
- Any additional information such as referral forms, claims, or any other documentation that you would like us to review
- The date of the incident or service
- Your signature, if sending in writing

If someone is filing a complaint or any appeal for you, you must designate (name) someone to represent you in your appeal. Blue Cross requires a signed, written request from you authorizing that person to act on your behalf.

Please mail the complaint or appeal to:

Blue Cross & Blue Shield of Rhode Island
Attention: Grievances and Appeals Unit
500 Exchange Street
Providence, Rhode Island 02903

How we protect your health information

Blue Cross is dedicated to protecting the privacy and confidentiality of your healthcare information. We maintain, use, and disclose confidential health information as permitted or required by applicable state and federal laws, such as the Rhode Island Confidentiality of Health Care Communications and Information Act and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We have administrative, technical, and physical safeguards in place to protect the privacy and security of your health information.

Protected health information (health information)* is information that relates to your past, present, or future physical or mental health or condition, or the past, present, or future payment for the provision of healthcare to you, including demographic information, received from or on behalf of a healthcare provider, health plan, clearinghouse, or employer, that either identifies you or could be reasonably used to identify you. It includes such information contained in any form or medium (such as electronic, oral, and paper).

Our employees protect your health information

All Blue Cross employees are trained in confidentiality and our privacy policies and procedures upon hire, and are required to read and sign a confidentiality statement upon hire and then each year afterwards. To further protect the privacy of our members' health information, employees' access to health information is limited to only the information that they need to do their jobs. Any employee who violates the confidentiality policy will be subject to disciplinary action.

You have the right to access your own health information

You have the right to access your own health information and the right to request an amendment of your health information in accordance with state and federal laws.

Providers must keep your information private and confidential

Providers are responsible for maintaining the privacy and confidentiality of your health information in accordance with applicable state and federal laws. Medical records must be kept in a secure area with access limited to authorized personnel. Effective record keeping practices must be in place to protect the integrity and privacy of your health information.

**All references to "health information" on pages 21-22 refer to "protected health information."*

When (and how) your health information is shared

We will share your health information with an individual who has been named by you as your personal representative and who has qualified for such designation in accordance with relevant state law. Before we will share health information with this person, you must submit a written notice that he/she is your personal representative.

You may also allow us to share your health information with anyone based on your written permission. We must get your written permission to use or share your health information for any purpose not described within the Notice of Privacy Practices. If you give us that permission, you may take back the permission in writing, which will be effective for future uses and sharing of health information. Taking back this permission will not be effective, however, for health information that we already have used or shared relying on the permission.

Permission will be required for any use or sharing of psychotherapy notes. We also must get your written permission to sell information about you to a third party or, in most circumstances, to use or share your health information to send you communications about products and services.

If you are covered by a plan sponsored by an employer (or employee organization, such as a union), we generally cannot share your health information with the employer (or other sponsor) of your health plan. We may provide employers (and other plan sponsors) information about who is enrolled in (or has disenrolled from) the group health plan as well as summary reports by the enrollees in your group health plan. The summary information will be stripped of demographic information about specific enrollees in the group health plan. If the sponsor of your group health plan takes appropriate steps to meet federal privacy regulations, we may share more detailed health information with the sponsor for the sponsor's administration of the group health plan.

For more information about how Blue Cross protects the privacy and confidentiality of your healthcare information, please view our Privacy Policy and Notice of Privacy Practices on **bcbsri.com**.

Notes

Notes

www.bcbsri.com

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