Subscriber Agreement

BlueValue Direct 2500

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

RENEWABILITY PROVISIONS

This *agreement* will automatically renew on the *plans* renewal date, which is October 1, 2013, providing your membership fees are paid. The only exceptions are described in Section 2.4 - When Your Coverage Ends.

Blue Cross Blue Shield of Rhode Island

WELCOME
Welcome to Blue Cross & Blue Cross Blue Shield of Rhode Island (BCBSRI). Below is a legal notice, some helpful tips, and phone numbers about your plan.

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

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

Peter Andruszkiewicz
President and Chief Executive Officer

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

HELPFUL TIPS

- Read all information provided, especially this Subscriber Agreement. Become familiar with services excluded from coverage (See Section 4.0 – Health Services Not Covered Under This Agreement.)
- In Section 8 – Glossary, there is a list of definitions of words used throughout this agreement. It is very helpful to become familiar with these words and their definitions.
- Identification Cards (ID) are provided to all *members*. The ID card must be shown when obtaining health care services. Your ID card should be kept in a safe location, just like money, credit card or other important documents. BCBSRI should be notified immediately if your ID card is lost or stolen.
- Our list of *network providers* changes from time to time. You may want to call our Customer Service Department in advance to make sure that a *provider* is a *network provider*.
- You are encouraged to choose a *personal physician*. Although no referral from a *personal physician* is needed to receive *covered health care services* from a specialist physician, *personal physicians* can help manage health care services.
- You are encouraged to become involved in your health care treatment by asking *providers* about all treatment plans available and their costs. You also are encouraged to take advantage of the preventive health services offered under this *agreement* to help you stay healthy and find problems before they become serious.

IMPORTANT TELEPHONE NUMBERS AND WEBSITES

Customer Service - (401) 459-5000 or **1-800-639-2227** or **Voice TDD 1-888-252-5051**.
Our normal business hours are Monday - Friday from 8:00 a.m. - 8:00 p.m. Please see Section 1.5 for more details.

Our Website - www.BCBSRI.com.

Recommended Preauthorization

Services for which *preauthorization* is recommended are marked with an asterisk (*) in the Summary of Medical Benefits. Rhode Island *network providers* are responsible to obtain recommended *preauthorization.* Please see Section 1.6 for more information.

- **Medical/Surgical -** call our Customer Service Department. Please see Section 1.6 for details.
- **Mental Health and Chemical Dependency -** call **1-800-274-2958** before having care. Lines are open 24 hours a day, 7 days per week. Please see Section 1.6 for details.

Required Preauthorization

Prescription drugs for which *preauthorization* is required are marked with the symbol (+) in the Summary of Pharmacy Benefits. Please see Section 1.6 and Section 3.27 for more information.

- **Prescription drugs -** ask your prescribing physician to call the number listed for the “Pharmacist” on the back of your ID card. To see if prescription drug requires *preauthorization,* call our Customer Service Department or visit our Web site.

BlueCard Access- 1-800-810-BLUE (2583) or visit the *BlueCard* PPO Doctor and Hospital finder web page at **www.bcbs.com**.

ELIGIBILITY	
Subscriber/Dependents	**See Section 2.1 – Who is Eligible for Coverage**
Subscriber	Eligible for coverage. See Section 2.1
Spouse	Not eligible for coverage.
Children	Not eligible for coverage.

Summary of Benefits

This is a summary of our coverage levels under this *agreement.* It includes information about *copayments, deductibles,* and some *benefit limits*. This summary gives you a general understanding of the coverage available under this *agreement.* For more detailed information, please read Section 3.0 for the description of coverage for each particular *covered health care service* along with the related exclusions. Read Section 4.0 for a list of general exclusions. Words or phrases used in this *agreement* that are in italics are defined in Section 8.0 – Glossary.

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

**Preauthorization* is recommended for the services marked with an asterisk (*). If you do not obtain *preauthorization* and the services are not *medically necessary* or the setting where services were received is determined to be inappropriate, we will not cover these services. *Network providers* in Rhode Island are responsible for obtaining *preauthorization* for all applicable *covered health care services*. When the *provider* is *non-network*, you are responsible for obtaining *preauthorization*. If you receive services from a *provider* that participates with an out of state (non-Rhode Island) Blue Cross or Blue Shield *plan*, you are responsible for obtaining *preauthorization*. See Section 8.0 – definition of *preauthorization* for details.

Summary of Medical Benefits

Benefit Description	Description	Benefit Limit/Notes	*Network Provider*	*Non-Network Provider*
Deductible The *deductible* applies to both *network and non-network* services separately.	**Individual Plan**	Per *calendar year*	$2,500	$5,000
Maximum Out-of-Pocket Expense The *maximum out-of-pocket expense* accumulates separately for n*etwork and non-network* services. The *deductible* is applied to the *maximum out of pocket expense.* It is applied separately *for network* and *non-network* services.	**Individual Plan**	Per *calendar year*	$7,500	$15,000

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
Ambulance	**Ground**		$50	NO	NO	The amount you pay is the same as *network provider.*		
	Air/Water	Up to the *maximum benefit* of $3,000 per occurrence.	$50	NO	NO	The amount you pay is the same as *network provider.*		
Behavioral Health - Mental Health	**Inpatient ***	Unlimited days at a *general hospital* or a *specialty hospital.*	50%	YES	YES	75%	YES	YES
	Outpatient , Intermediate Care Services*	See Section 3.2 for details about partial *hospital program*, intensive *outpatient program*, adult intensive services, and child and family intensive treatment.	50%	YES	YES	75%	YES	YES
	In the office/in your home rendered by PCP or Specialist (includes individual and group sessions.)	First or second submitted claim for an office visit in a *calendar year*. Benefit limit applies to all office visits, including but not limited to behavioral health, except preventive office visits and chiropractic visits. Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.27 –	$30	NO	NO	75%	YES	YES

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
Behavioral Health - Mental Health		Prescription Drugs for details.						
	In the office/in your home rendered by PCP or Specialist (includes individual and group sessions.)	Subsequent submitted claims for office visits in a *calendar year*. Benefit limit applies to all office visits, including but not limited to behavioral health, except preventive office visits and chiropractic visits.	50%	YES	YES	75%	YES	YES

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
Behavioral Health – Chemical Dependency Treatment	**Inpatient, Chemical Dependency Treatment Facility ***	Detoxification – unlimited days per *calendar year*. Residential/ Rehabilitation – unlimited days per *calendar year*.	50%	YES	YES	75%	YES	YES
	Outpatient , In a Chemical Dependency Treatment facility (outpatient), Intermediate Care Services *	Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.27 – Prescription Drugs for details. See Section 3.2 for details about partial hospital program, intensive outpatient program, adult intensive services, and child and family intensive treatment.	50%	YES	YES	75%	YES	YES
	In the office/in your home rendered by PCP or Specialist	First or second submitted claim for an office visit in a *calendar year*. Benefit limit applies to all office visits, including but not limited to behavioral health, except preventive	$30	NO	NO	75%	YES	YES

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
Behavioral Health – Chemical Dependency Treatment		office visits and chiropractic visits. Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.27 – Prescription Drugs for details.						
	In the office/in your home rendered by PCP or Specialist	Subsequent submitted claims for office visits in a *calendar year*. Benefit limit applies to all office visits, including but not limited to behavioral health, except preventive office visits and chiropractic visits.	50%	YES	YES	75%	YES	YES
Cardiac Rehabilitation	**Outpatient**	Benefit is limited to 18 weeks or 36 visits (whichever occurs first) per covered episode. See Section 3.2 for details.	50%	YES	YES	75%	YES	YES

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
Chiropractic Medicine	**In a Provider's office**	12 visits per *calendar year.*	50%	YES	YES	75%	YES	YES
Contraceptives		Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.27 – Prescription Drugs for details.	Coverage varies based on type of contraceptive service. See Section 3.5.					
Dental Care	**Hospital Emergency Room (when services are due to accidental injury to *sound natural teeth)***	First submitted claim for an emergency room visit in a *calendar year* for any condition, including but not limited to emergency room visit for dental care.	$200	NO	NO	The amount you pay is the same as *network provider.*		
		Subsequent submitted claim for an emergency room visit in a *calendar year* for any condition	50%	YES	YES			
	Services connected to dental care performed in Outpatient Facility *	See Section 3.5 for benefit limitations.	50%	YES	YES	75%	YES	YES

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
	In an office, doctor or dentist (when services are due to accidental injury to *sound natural teeth)*	First or second submitted claim for an office visit in a *calendar* year. Benefit limit applies to all office visits, including but not limited to dental care for an accidental injury , except preventive office visits and chiropractic visits. Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.27 – Prescription Drugs for details.	$30	NO	NO	75%	YES	YES
		Subsequent submitted claims for office visits in a *calendar year.* Benefit limit applies to all office visits, including but not limited to dental care for an accidental injury, except preventive office visits and chiropractic visits.	50%	YES	YES	75%	YES	YES

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
	Cleanings (Prophylaxis)	Limited to one (1) cleaning per *calendar year*	0%	NO	NO	75%	YES	YES
	Bitewing x-rays	Limited to one (1) set per *calendar year*.	0%	NO	NO	75%	YES	YES
Dialysis Services	**Inpatient/ Outpatient/ in your home**		50%	YES	YES	75%	YES	YES
Durable Medical Equipment, Medical Supplies, Diabetic Supplies, Enteral Formula and Food, and Prosthetic Devices	**Outpatient Durable Medical Equipment***	*Preauthorization* recommended for certain services. See Section 3.8 for details. Must be provided by a licensed medical supply provider	50%	YES	YES	75%	YES	YES
	Outpatient Medical Supplies	Must be provided by a licensed medical supply provider	50%	YES	YES	75%	YES	YES

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
Durable Medical Equipment, Medical Supplies, Diabetic Supplies, Enteral Formula and Food, and Prosthetic Devices	**Outpatient Diabetic Supplies/Equipment purchased at licensed medical supply provider (other than not a pharmacy) ***	See the Summary of Pharmacy Benefits for supplies purchased at a pharmacy	50%	YES	YES	75%	YES	YES
	Outpatient Prosthesis*	Must be provided by a licensed medical supply provider	50%	YES	YES	75%	YES	YES
	Enteral formula delivered through a feeding tube	Must be sole source of nutrition.	50%	YES	YES	75%	YES	YES
	Enteral formula or food taken orally*	Benefit is limited to a *maximum benefit* of $2,500 per *member* per *calendar year*. See Section 3.8 for details.	50%	YES	YES	The amount you pay is the same as *network provider.*		

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
	Hair Prosthesis (Wigs)	Benefit is limited to the *maximum benefit* of $350 per *member* per *calendar year* when worn for hair loss suffered as a result of cancer treatment.	50%	YES	YES	The amount you pay is the same as *network provider.*		
Early Intervention Services (EIS)	**Early Intervention Services (EIS)**	Up to the *maximum benefit* of $5,000 per child, from birth to 36 months, per *calendar year*. The *provider* must be certified as an EIS *provider* by the Rhode Island Department of Human Services.	0%	NO	NO	The amount you pay is the same as *network provider.*		
Education	**Asthma Management**	First or second submitted claim for an office visit in a *calendar* year. Benefit limit applies to all office visits, including but not limited to asthma management, except preventive office visits and chiropractic visits.	$30	NO	NO	75%	YES	YES

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
Education		Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.27 – Prescription Drugs for details.						
		Subsequent submitted claims for office visits in a *calendar year.* Benefit limit applies to all office visits, including but not limited to asthma management, except preventive office visits and chiropractic visits.	50%	YES	YES	75%	YES	YES
Experimental/ Investigational Services			Coverage varies based on type of service. See Section 3.11.					
Hearing	**Hearing Exam**	First or second submitted claim for an office visit in a *calendar* year. Benefit limit applies to all office visits, including but not limited to hearing exams, except preventive office visits and chiropractic visits.	$30	NO	NO	75%	YES	YES

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
Hearing		Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.27 – Prescription Drugs for details.						
		Subsequent submitted claims for office visits in a *calendar year.* Benefit limit applies to all office visits, including but not limited to hearing exams, except preventive office visits and chiropractic visits.	50%	YES	YES	75%	YES	YES
	Diagnostic Testing		50%	YES	YES	75%	YES	YES
	Hearing Aids	Per three (3) year period, a *maximum benefit* of $1500 per ear for a *member* under 19; a *maximum benefit* of $700 per ear for a *member* 19 and older.	0%	NO	NO	The amount you pay is the same as *network provider.*		

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
Hemophilia Services	**Outpatient**	Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.27 – Prescription Drugs for details. Coverage varies based on type of hemophilia service. .	50%	YES	YES	75%	YES	YES
Home Health Care	**In your home**	Intermittent skilled services when billed by a home health care agency. Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.27 – Prescription Drugs for details.	50%	YES	YES	75%	YES	YES
Hospice Care	**Inpatient/in your home**	When provided by an approved hospice care *program*. Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.27 – Prescription Drugs for details.	50%	YES	YES	75%	YES	YES

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
Hospital Emergency Room Services	**Hospital Emergency Room**	First hospital emergency room visit of the *calendar year* for any condition, including but not limited to emergency room visit for dental care.	$200	NO	NO	The amount you pay is the same as *network provider.*		
		Second and subsequent emergency room visit of the *calendar year* for any condition	50%	YES	YES			
Human Leukocyte Antigen Testing	**Human Leukocyte Antigen Testing**	See Section 3.17 for limitations.	50%	YES	YES	75%	YES	YES
Infertility	**Inpatient/ outpatient/in a doctor's office**	Coverage is limited to a married female *member* aged 25 to 42. $100,000 lifetime *maximum benefit* applies. See Section 3.19 for detailed information. Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.27 – Prescription Drugs for details.	20%	YES	NO	20%	YES	NO

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
Infusion Therapy	**Outpatient**	Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.27 – Prescription Drugs for details.	50%	YES	YES	75%	YES	YES
	In the doctor's office/ in your home	Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.27 – Prescription Drugs for details.	50%	YES	YES	75%	YES	YES
Inpatient Hospital Services	**Inpatient***	Unlimited days at *general hospital* or *a specialty hospital*	50%	YES	YES	75%	YES	YES
Inpatient Physician Hospital Visits	**Inpatient**		50%	YES	YES	75%	YES	YES
Inpatient Rehabilitation Facility	**Inpatient***	Maximum of 45 days per *calendar year*	50%	YES	YES	75%	YES	YES

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
Office Visits	**Hospital based Adult Clinic visits and Pediatric Clinic visit**	First or second submitted claim for an office visit in a *calendar* year. Benefit limit applies to all office visits, including but not limited to clinic visits, except preventive office visits and chiropractic visits. Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.27 – Prescription Drugs for details.	$30	NO	NO	75%	YES	YES
		Subsequent submitted claims for office visits in a *calendar year.* Benefit limit applies to all office visits, including but not limited to clinic visits, except preventive office visits and chiropractic visits.	50%	YES	YES	75%	YES	YES

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
	Personal Care Physician **(PCP) and Specialist** **(Sick visit for PCP. See Prevention and Early Detection Services for coverage of annual preventive office visit.** **Routine and non-routine visits for specialists.)**	First or second submitted claim for a office visit in a *calendar* year. Benefit limit applies to all office visits, including but not limited to PCP and specialist visits, except preventive office visits and chiropractic visits. Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.27 – Prescription Drugs for details.	$30	NO	NO	75%	YES	YES
		Subsequent submitted claims for office visits in a *calendar year.* Benefit limit applies to all office visits, including but not limited to PCP and specialist visits, except preventive office visits and chiropractic visits.	50%	YES	YES	75%	YES	YES

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
	Podiatrist Services	First or second submitted claim for an office visit in a *calendar* year. Benefit limit applies to all office visits, including but not limited to podiatrist office visits, except preventive office visits and chiropractic visits. Routine foot care is NOT covered. Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.27 – Prescription Drugs for details.	$30	NO	NO	75%	YES	YES
		Subsequent submitted claims for office visits in a *calendar year.* Benefit limit applies to all office visits, including but not limited to podiatrist office visits, except preventive office visits and chiropractic visits.	50%	YES	YES	75%	YES	YES
	Allergy Injections		50%	YES	YES	75%	YES	YES

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
Organ Transplants	**Transplant**		50%	YES	YES	75%	YES	YES
	Travel Expense	Up to the *maximum benefit* of $5,000 per transplant for patient and family for food, travel, and lodging when transplant rendered by Blue Distinction Centers for Transplants	50%	YES	YES	75%	YES	YES
Physical /Occupational Therapy	**Outpatient hospital / In a doctor's/ therapist's office**	Limited to thirty (30) physical therapy visits and thirty (30) occupational therapy visits per *calendar year*	50%	YES	YES	75%	YES	YES
Pregnancy Services and Nursery Care	**Pre-natal, delivery, and postpartum services.**		50%	YES	YES	75%	YES	YES
Prescription drugs, other than *Specialty Prescription drugs,* dispensed and administered by a licensed health care *provider* (other than a pharmacist)	**Medications other than injected and infused drugs.**		**Are included in the *allowance* for the medical service being rendered.** See **Section 3.27** for details.					
	Injectable drugs		50%	YES	YES	75%	YES	YES
	Infused drugs		50%	YES	YES	75%	YES	YES

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
Prescription Drugs Purchased at a Retail, Specialty, or Mail Order Pharmacy			See **Pharmacy Benefits** section and **Summary of Pharmacy Benefits** for details.					
Prevention **and Early Detection Services**	**Adult annual preventive visit**	One (1) routine adult physical examination per *calendar year* per *member* will be covered.	0%	NO	NO	75%	YES	YES
	Well woman annual preventive visit	One (1) routine gynecological examination per *calendar year* per female *member* will be covered.	0%	NO	NO	75%	YES	YES
	Pediatric preventive office visit	Well-Child Office Visits: Birth - 15 months: 8 visits; 16 - 35 months: 3 visits; 36 months - 19 years: 1 per *calendar year*.	0%	NO	NO	75%	YES	YES
	Pediatric preventive clinic		0%	NO	NO	75%	YES	YES
	Diabetes education	Individual and group sessions are covered.	0%	NO	NO	75%	YES	YES
	Nutritional counseling	Unlimited visits per *calendar year* when prescribed by a physician.	0%	NO	NO	75%	YES	YES

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
Prevention **and Early Detection Services**	**Smoking cessation counseling**	For nicotine replacement therapy (NRT) and smoking cessation prescription drugs. See Section 3.27 – Prescription Drugs for details.	0%	NO	NO	75%	YES	YES
	Adult Immunizations		0%	NO	NO	75%	YES	YES
	Pediatric Immunizations		0%	NO	NO	75%	YES	YES
	Travel Immunizations		0%	NO	NO	75%	YES	YES
	Preventive screenings	Coverage includes, but is not limited to, the following: mammograms, pap smear, PSA test, flexible sigmoidoscopy, colonoscopy, double contrast barium enema, and fecal occult blood tests. See the Summary of Pharmacy Benefits.	0%	NO	NO	75%	YES	YES
Radiation Therapy /Chemotherapy Services	**Outpatient**		50%	YES	YES	75%	YES	YES
	In a doctor's office		50%	YES	YES	75%	YES	YES

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
Respiratory Therapy			50%	YES	YES	75%	YES	YES
Skilled Nursing Facility Care*	**Skilled or Sub-acute**		50%	YES	YES	75%	YES	YES
Speech Therapy*	**Outpatient /in a doctor's/ therapist's office**	Limited to thirty (30) speech therapy visits per *calendar year.*	50%	YES	YES	75%	YES	YES
Surgery Services	**Inpatient**		50%	YES	YES	75%	YES	YES
	Outpatient		50%	YES	YES	75%	YES	YES
	In a doctor's office		50%	NO	YES	75%	YES	YES
Tests, Imaging*, and Labs (includes machine tests and x-rays)	**Outpatient Hospital Facility/ Outpatient Non-Hospital facility including in a Doctor's office, urgent care center, or free-standing laboratory**	Applies to the following diagnostic imaging services: • MRI; • MRA; • CAT scans; • CTA scans; • PET scans; and • Nuclear Cardiac Imaging. *Preauthorization* is recommended for these diagnostic imaging services.	50%	YES	YES	75%	YES	YES

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
		For tests, imaging and lab, other than the diagnostic imaging services listed above.	50%	YES	YES	75%	YES	YES
	Diagnostic colorectal services	Including, but not limited to, fecal occult blood testing , flexible sigmoidoscopy , colonoscopy, and barium enema . See *Prevention* and Early Detection Services – Preventive Screening for preventive colorectal services.	50%	YES	YES	75%	YES	YES
	Lyme Disease-Diagnosis/ Treatment		50%	YES	YES	75%	YES	YES
Urgent care facility	**Urgent care facility/walk-in**	See Section 8.0 – definition of *urgent care center.*	50%	YES	YES	The amount you pay is the same as *network provider.*		
Vision care services	**In a doctor's office** **One routine eye exam per *calendar year*.**	First or second submitted claim for an office visit in a *calendar* year. Benefit limit applies to all office visits, including but not limited to vision care office visits, except	$30	NO	NO	75%	YES	YES

Service	Service Type, Provider, or Place of Service	Benefit Limit	***Network provider-*** **For a *covered heath care service* you pay:**			***Non-network provider*** **-For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *deductible* apply?**	**Does the *maximum out-of-pocket expense* apply?**
		preventive office visits and chiropractic visits. Prescription drug coverage benefit level is based on type of service and site of service. See Section 3.27 – Prescription Drugs for details.						
		Subsequent submitted claims for office visits in a *calendar year.* Benefit limit applies to all office visits, including but not limited to vision care office visits, except preventive office visits, chiropractic visits, an oral (dental) examination.	50%	YES	YES	75%	YES	YES

Only applies to the Summary of Pharmacy Benefits:

Required Preauthorization
Prescription drugs for which *preauthorization* is required are marked with the symbol (+) in the Summary of Pharmacy Benefits.

- **Prescription drugs -** ask your prescribing physician to call the number listed for the "Pharmacist" on the back of your ID card. To see if prescription drug requires *preauthorization,* call our Customer Service Department or visit our Web site.

(+) *Preauthorization* is required for certain brand name prescription drugs and certain *specialty prescription drugs*. If *preauthorization* is not obtained, you will be required to pay for the prescription drug at the pharmacy. You can ask us to consider reimbursement after you receive the prescription drug by following the prescription drug *preauthorization* process. For details on how to obtain prescription drug *preauthorization* for a prescription drug, see the subsection "How to Obtain Prescription Drug Preauthorization" below. For a list of prescription drugs that require *preauthorization*, visit our Web site at BCBSRI.com or call our Customer Service Department at (401) 459-5000 or 1-800-639-2227.

Prescription drugs in our *formulary* are placed into the following tiers, or levels, for *copayment* purposes:
Tier 1 – generally low cost generic drugs;
Tier 2 – generally high cost generic and preferred brand name drugs;
Tier 3 – other generic and non-preferred brand name drugs; and
Tier 4 – *specialty prescription drugs*.

Below indicates the tier structure and the amount that you are responsible to pay. The tier placement of our *formulary* is subject to change.

Note: To find out what tier a prescription drug is, call our Customer Service Department at (401) 274-3500 or 1-800-564-0888.

As noted below a *prescription drug deductible* is applied to Tier 2, Tier 3, and Tier 4 prescription drugs. The *deductible* for your medical services does NOT apply.

Summary of Pharmacy Benefits

Benefit Description	Description	Benefit Limit/Notes	*Network Pharmacy*	*Non-Network Pharmacy*
Prescription Drug Deductible Applies to *network pharmacy* services ONLY. This *calendar year prescription drug deductible* only applies to Tier 2, Tier 3 and Tier 4 prescription drugs.	**Individual Plan**	The amount applied to the *prescription drug deductible* is based on the lower of our *pharmacy allowance* or the retail cost of the drug. The *prescription drug deductible* is NOT applied to the *maximum out of pocket expense.*	$500 per *member* per *calendar year*.	None

Type and Site of Service	Benefit Limit/Notes	Tier	***Network pharmacy*** **For a *covered health care service* you pay:**			***Non-network pharmacy*** **For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *prescription drug deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *prescription drug deductible* apply?**	**Does the *maximum out of pocket expense* apply?**
Prescription Drugs, other than *Specialty Prescription Drugs* when purchased at a Retail or Specialty Pharmacy	*Copayment* applies per each 30-day supply or portion thereof of maintenance and non-maintenance prescription drugs. You are responsible to pay the lower of your *copayment* or the retail price of the drug.	**Tier 1**	$4	NO	NO	Not Covered	Not Covered	Not Covered
		Tier 2	50%	YES	NO	Not Covered	Not Covered	Not Covered
		Tier 3	50%	YES	NO	Not Covered	Not Covered	Not Covered
		Tier 4	See *specialty prescription drug* section below	See *specialty prescription drug* section below	See *specialty prescription drug* section below	See *specialty prescription drug* section below	See *specialty prescription drug* section below	See *specialty prescription drug* section below
when purchased at a Mail Order Pharmacy	Up to a 90-day supply of maintenance and non-maintenance prescription drugs. You are	**Tier 1**	$10	NO	NO	Not Covered	Not Covered	Not Covered
		Tier 2	50%	YES	NO	Not Covered	Not Covered	Not Covered

Type and Site of Service	Benefit Limit/Notes	Tier	***Network pharmacy*** **For a *covered health care service* you pay:**			***Non-network pharmacy*** **For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *prescription drug deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *prescription drug deductible* apply?**	**Does the *maximum out of pocket expense* apply?**
	responsible to pay the lower of your *copayment* or the retail price of the drug. Nicotine replacement therapy (NRT) and smoking cessation prescription drugs are not covered when purchased at a mail order pharmacy.	**Tier 3**	50%	YES	NO	Not Covered	Not Covered	Not Covered
		Tier 4	See *specialty prescription drug* section below.	See *specialty prescription drug* section below.	See *specialty prescription drug* section below.	See *specialty prescription drug* section below.	See *specialty prescription drug* section below.	See *specialty prescription drug* section below.
Infertility Prescription drugs, purchased at any Pharmacy	Coverage is limited to a married female *member* aged 25 to 42. $100,000 lifetime *maximum benefit* applies.	**Tier 1**	20%	NO	NO	Not Covered	Not Covered	Not Covered
		Tier 2	20%	YES	NO	Not Covered	Not Covered	Not Covered
		Tier 3	20%	YES	NO	Not Covered	Not Covered	Not Covered

Type and Site of Service	Benefit Limit/Notes	Tier	***Network pharmacy*** **For a *covered health care service* you pay:**			***Non-network pharmacy*** **For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *prescription drug deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *prescription drug deductible* apply?**	**Does the *maximum out of pocket expense* apply?**
	Your *copayment* is based on the lower of the *pharmacy allowance* or the retail cost of the drug.	**Tier 4**	See *specialty prescription drug* section below.	See *specialty prescription drug* section below.	See *specialty prescription drug* section below.	See *specialty prescription drug* section below.	See *specialty prescription drug* section below.	See *specialty prescription drug* section below.
Over-the-counter (OTC) preventive drugs, purchased at any pharmacy	Must be prescribed by a physician. See Pharmacy Benefits for details.		0%	NO	NO	Not Covered	Not Covered	Not Covered
NRT and Smoking Cessation Prescription Drugs, purchased at a Retail or Specialty Pharmacy.	Must be prescribed by a physician. See Pharmacy Benefits for details. Nicotine replacement therapy and smoking cessation prescription drugs are not covered when purchased at a mail order pharmacy.		0%	NO	NO	Not Covered	Not Covered	Not Covered

Type and Site of Service	Benefit Limit/Notes	Tier	***Network pharmacy*** **For a *covered health care service* you pay:**			***Non-network pharmacy*** **For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *prescription drug deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *prescription drug deductible* apply?**	**Does the *maximum out of pocket expense* apply?**
Specialty Prescription Drugs								
when purchased at a Specialty Pharmacy(+)	*Copayment* applies per each 30-day supply or applies per recommended treatment interval.	**Tier 4**	$200 You are responsible to pay the lower of your *copayment* or the retail price of the drug.	YES	NO	50% Our reimbursement is based on the *pharmacy allowance.* You are responsible to pay up to the retail cost of the drug.	NO	NO
when purchased at a Retail Pharmacy(+)	*Specialty Prescription Drugs* purchased at a Retail Pharmacy are reimbursed at the *non-network* level of coverage.	**Tier 4**	50% Our reimbursement is based on the *pharmacy allowance.* You are responsible to pay up to the retail cost of the drug.	YES	NO	50% Our reimbursement is based on the *pharmacy allowance.* You are responsible to pay up to the retail cost of the drug.	NO	NO
when purchased at a Mail Order Pharmacy(+)		**Tier 4**	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

Type and Site of Service	Benefit Limit/Notes	Tier	***Network pharmacy*** **For a *covered health care service* you pay:**			***Non-network pharmacy*** **For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *prescription drug deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *prescription drug deductible* apply?**	**Does the *maximum out of pocket expense* apply?**
Infertility *specialty prescription drugs* purchased at a Specialty Pharmacy (+)	Coverage is limited to a married female *member* aged 25 to 42. $100,000 lifetime *maximum benefit* applies.	**Tier 4**	20% Your *copayment* is based on the lower of our *allowance* or the retail cost of the prescription drug.	YES	NO	20% Our reimbursement is based on the *pharmacy allowance.* You are responsible to pay up to the retail cost of the drug.	NO	NO
Infertility *specialty prescription drugs* purchased at a Retail Pharmacy (+)	Coverage is limited to a married female *member* aged 25 to 42. $100,000 lifetime *maximum benefit* applies. *Specialty Prescription Drugs* purchased at a Retail Pharmacy are reimbursed at	**Tier 4**	20% Our reimbursement is based on the *pharmacy allowance.* You are responsible to pay up to the retail cost of the drug	YES	NO	20% Our reimbursement is based on the *pharmacy allowance.* You are responsible to pay up to the retail cost of the drug	NO	NO

Type and Site of Service	Benefit Limit/Notes	Tier	***Network pharmacy*** **For a *covered health care service* you pay:**			***Non-network pharmacy*** **For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *prescription drug deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *prescription drug deductible* apply?**	**Does the *maximum out of pocket expense* apply?**
	the *non-network* level of coverage.							
Diabetic equipment and supplies								
when purchased at a Retail or Specialty Pharmacy	Glucometers, Test Strips, Lancet and Lancet Devices, and Miscellaneous Supplies (including calibration fluid). You are responsible to pay the lower of your *copayment* or the retail price of the drug.	**Tier 1**	$4	NO	NO	Not Covered	Not Covered	Not Covered
		Tier 2	50%	YES	NO	Not Covered	Not Covered	Not Covered
		Tier 3	Diabetic equipment and supplies are only placed in Tier 1 or Tier 2. See above.					
		Tier 4						

Type and Site of Service	Benefit Limit/Notes	Tier	***Network pharmacy*** **For a *covered health care service* you pay:**			***Non-network pharmacy*** **For a *covered health care service* you pay the difference between the charge amount and the *allowance* plus:**		
			Your *copayment*	**Does the *prescription drug deductible* apply?**	**Does the *maximum out of pocket expense* apply?**	**Your *copayment***	**Does the *prescription drug deductible* apply?**	**Does the *maximum out of pocket expense* apply?**
when purchased at a Mail Order Pharmacy	Glucometers, Test Strips, Lancet and Lancet Devices, and Miscellaneous Supplies (including calibration fluid). You are responsible to pay the lower of your *copayment* or the retail price of the drug.	**Tier 1**	$10	NO	NO	Not Covered	Not Covered	Not Covered
		Tier 2	50%	YES	NO	Not Covered	Not Covered	Not Covered
		Tier 3	Diabetic equipment and supplies are only placed in Tier 1 or Tier 2. See above.					
		Tier 4						
Prescription drugs, other than *Specialty Prescription Drugs,* dispensed and administered by a licensed health care *provider* (other than a pharmacist).	**See the Summary of Medical Benefits.**							

Blue Cross & Blue Shield of Rhode Island
SUBSCRIBER AGREEMENT

TABLE OF CONTENTS

1.0 INTRODUCTION

1.1 Agreement and Its Interpretation

Our entire contract with you consists of this *agreement* and your application which is made a part of this *agreement.* In the absence of fraud, all your statements in the application are representations and not warranties. We will make a determination regarding your eligibility for benefits and construe the provisions of this *agreement* subject to your right to appeal or to take legal action as described in Section 7.0.

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

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

1.2 How to Find What You Need to Know in this Agreement

The Summary of Benefits at the front of this *agreement* will show you:

- what health care services are covered under this *agreement;*
- any *benefit limits*, *copayments* and *deductibles* you must pay; and
- Services for which *preauthorization* is recommended or required.

The Table of Contents will help you find the order of the sections, as they appear in the *agreement*:

- Section 1.0 - important introductory information;
- Section 2.0 - information about eligibility;
- Section 3.0 - *covered health care services;*
- Section 4.0 - health care services which are not covered under this *agreement;*
- Section 5.0 - how we pay for your *covered health care services*;
- Section 6.0 - how we coordinate benefits when you are covered by more than one *plan*;
- Section 7.0 - how to file a *claim* and how to appeal a *claim;* and
- Section 8.0 - words with special meaning.

1.3 Words With Special Meaning

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 health care coverage. Section 8.0 – Glossary defines many of these words.

The sections below also define certain words and phrases:

- Section 3.0 - Covered Health Care Services;

- Section 6.0 - How We Coordinate Your Benefits When You Are Covered By More Than One Plan;
- Section 7.0 - How To File And Appeal A Claim; and
- Section 7.7 - Our Right of Subrogation and Reimbursement.

1.4 You and Blue Cross & Blue Shield of Rhode Island

We, Blue Cross & Blue Shield of Rhode Island, agree to provide coverage for *medically necessary covered health care services* listed in this *agreement.* We only cover a service in this *agreement* if it is *medically necessary*. We review medical necessity in accordance with our medical policies and related guidelines. The term *medically necessary* is defined in Section 8.0 - Glossary. It does not include all medically appropriate services.

This *agreement* provides coverage for health care services that we have reviewed and determined are eligible for coverage. Health care services which we have not reviewed or which we have reviewed and determined are not eligible for coverage are not covered under this *agreement*. If a service or category of service is not listed as covered, it is not covered under this *agreement.* Section 3.0 lists the health care services covered under this *agreement* along with their related exclusions. Section 4.0 lists general exclusions.

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

- the assignment of an American Medical Association (AMA) Current Procedural Terminology (CPT) code in the annual CPT publication;
- final FDA approval;
- the assignment of processing codes other than CPT codes or approval by governing or regulatory bodies other than the FDA;
- submission to us of a *claim* meeting the criteria of (a), (b) or (c) above; and
- the first date generally available in pharmacies (for prescription drugs only).

During the review period described above, *new services* are not covered under this *agreement.*

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

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

Entitlements for payment shall not be more than our *allowance*, as defined in Section 8.0. All our payments are subject to the terms and conditions outlined in this *agreement.*

1.5 Customer Service/General Information

If you have questions about your *benefits* under this *agreement*, call the Blue Cross & Blue Shield of Rhode Island (BCBSRI) Customer Service Department at (401) 459-5000 or 1-800-639-2227 or Voice TDD 1-888-252-5051. Our normal business hours are Monday - Friday from 8:00 a.m. - 8:00 p.m. and Saturday from 8:00 a.m. - 2:00 p.m. If you call after normal business hours, our answering service will take your call. A BCBSRI Customer Service Representative will return your call on the next business day. When you call, please have your *member* ID number ready.

Below are a few examples of when you should call our Customer Service Department:

- To learn if a *provider* participates with Blue Cross & Blue Shield of Rhode Island's designated *BlueCard* PPO *network;*
- To ask questions and get information about your coverage;
- To file a *complaint* or *administrative appeal* (See Section 7.2);
- To file an appeal about a medical necessity determination or learn about the status of your appeal (See Section 7.3); or
- To ask for a HIPAA (Health Insurance Portability and Accountability Act) certificate of creditable coverage (See Section 2.4- When Your Coverage Ends).

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

Our medical policies can be found on our website, BCBSRI.com. The medical policies are written to help administer *benefits* for the purpose of *claims* payment. They are made available to you for informational purposes and are subject to change. Medical policies are not meant to be used as a guide for your medical treatment. Your medical treatment remains a decision made by you with your *doctor*.

If you have any questions about the medical information in our medical policies, we suggest you give a copy of the medical policy to your *doctor* and talk with your *doctor* about the policy. Please call our Customer Service Department with any questions you have.

1.6 Preauthorization

Services for which *preauthorization* is recommended are marked with an asterisk (*) in the Summary of Medical Benefits. *Preauthorization* is defined in Section 8.0. *Network providers* in Rhode Island are responsible for obtaining *preauthorization* for all applicable *covered health care services*. In some circumstances, you are responsible to obtain *preauthorization*. In order for you to obtain *preauthorization* for a *covered health care service*, please do the following:

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

If you are responsible for obtaining *preauthorization*, we will send to you notification of the *preauthorization* determination within fourteen (14) calendar days from receipt of the request or prior to the date of service.

Expedited Preauthorization Review
You may request an expedited *preauthorization* review if the circumstances are an emergency. If an expedited *preauthorization* review is received by us, we will respond to you with a determination within seventy two (72) hours following receipt of the request.

Services for which *prescription drug preauthorization* is required are marked with the symbol (+) in the Summary of Pharmacy Benefits. To obtain the required *preauthorization* for certain covered prescription drugs please request your prescribing physician to call the number listed for the "Pharmacist" on the back of your ID card. You can call our Customer Service Department at (401) 459-5000 or 1-800-639-2227 or visit our Web site at BCBSRI.com to see if a prescription drug requires *prescription drug preauthorization*. *Prescription drug preauthorization* is defined in Section 3.27.

1.7 Our Right to Receive and Release Information About You

We are committed to maintaining the confidentiality of your health care information. However, in order for us to make available quality, cost-effective health care coverage to you, we may release and receive information about your health, treatment, and condition to or from authorized *providers* 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 health insurance *claims*;
- administration of *claim* payments;
- health care operations;
- case management and *utilization review*; and
- coordination of health care *benefits.*

Our release of information about you is regulated by law. Please see the Rhode Island Confidentiality of Health Care Communications and Information Act, §§ 5-37.3-1 et seq. of the Rhode Island General Laws, the Health Insurance Portability and Accountability Act Final Privacy Regulations, 45 C.F.R. §§ 160.101 et seq., the Gramm-Leach-Bliley Financial Modernization Act, 15 U.S.C. §§ 6801-6908, and Regulation 100 adopted by the Rhode Island Office of the Health Insurance Commissioner (OHIC).

1.8 Our Right to Approve Alternative Benefits

We may in our sole discretion cover *benefits* not listed in this *agreement* or *benefits* that are excluded (not covered). This is our right to approve alternative benefits. Alternative benefits are health service specific and time-limited authorizations which must be pre-approved by us for each person. Alternative benefits are only offered on an individual, case-by-case basis when approved by us.

We approve alternative benefits based upon information that a *covered health care service* may be less effective than a requested alternative benefit. We get this information from your treating physician. We determine whether covering the alternative benefit will not only be helpful to you, but be more cost effective than a covered alternative. This review takes place in our Case Management Department. It includes the review of a Medical Director.

The determination by us of whether to cover an alternative benefit is solely for the purpose of *claims* payment and the administration of health benefits under this *agreement*. Your treatment remains a decision made by you with your *doctor*. Any decision to cover or not to cover alternative benefits is within our sole discretion. Any decision not to approve alternative benefits made by us in good faith is binding upon you.

If we approve an alternative benefit, you must verbally agree to our specific terms and conditions. You must sign a letter of *agreement* acknowledging acceptance of the specific terms and conditions of the alternative benefits.

We do not make alternative benefits available to all *members*. We do not make them available to any *member* a second time without additional approval. Alternative *benefits* must be consistent with our goals to offer cost-effective health care *benefits*. *Copayments* and *deductibles* for alternative *benefits* will be applied based on how *copayments* and *deductibles* would be applied for similar *covered health care services*.

1.9 Our Right to Conduct Utilization Review

To be sure a *member* receives appropriate *benefits*; we reserve the right to do utilization *review.* We also reserve the right to contract with an organization to conduct *utilization review* on our behalf. If another company does utilization *review* on our behalf, the company will act as an independent contractor. The company is not a partner, agent, or employee of Blue Cross & Blue Shield of Rhode Island.

This *agreement* provides coverage only for *medically necessary* care. The determination, by an entity conducting *utilization review,* whether a service is *medically necessary* is solely for the purpose of *claims* payment and the administration of your health benefit *plan.* It is not a professional medical judgment.

Although we may conduct *utilization review*, Blue Cross & Blue Shield of Rhode Island does not act as a health care *provider.* We do not furnish medical care. We do not make medical judgments. You are not prohibited from having a treatment or

hospitalization for which reimbursement has been denied. Nothing here will change or affect your relationship with your *provider(s).*

1.10 Your Right to Choose Your Own Provider

Your relationship with your *provider* is very important. This *agreement* is intended to encourage the relationship between you and your *provider*. However, we are not obligated to provide you with a *provider.* Also, we are not liable for anything your *provider* does or does not do. We are not a health care *provider.* We do not practice medicine, furnish health care, or make medical judgments.

We review *claims* for payment to determine if the *claims*:

- were properly authorized;
- constitute *medically necessary* services for the purpose of benefit payment; and
- are *covered health care services* under this *agreement.*

The determination by us of whether a service is *medically necessary* is solely for the purpose of *claims* payment and the administration of health *benefits* under this *agreement*. It is not an exercise of professional medical judgment.

1.11 How to Select a Health Care Provider

When you select a health care *provider*, refer to the HealthMate™ Coast to Coast Provider Network Directory to find out if your health care *provider* is a member of Preferred Blue. Preferred Blue is Blue Cross & Blue Shield of Rhode Island's designated *BlueCard* PPO *network*. You may visit our Web site at BCBSRI.com to find out this information as well.

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

1.12 Your Responsibility To Pay Your Providers

Covered health care services may be subject to *benefit limits*, *deductibles*, and *copayments* as shown in the Summary of Benefits. It is your responsibility and obligation under this *agreement* to pay *network providers* the *deductible, copayment*, and the difference between the *maximum benefit* and our *allowance* (if any) that may apply to *covered health care services*.

Your *provider* may require payment at the time of service or may bill you after the service. If you do not pay your *provider*, he or she may decline to provide current or future services or may pursue payment from you. Your *provider* may, for example, begin collection proceedings against you. For more information, see Section 5.0 - How Your Covered Health Care Services Are Paid.

2.0 ELIGIBILITY

This section of the *agreement* describes:

- who is eligible for coverage;
- when coverage begins;
- how to add or remove family members;
- when coverage ends;
- continuation of coverage.

2.1 Who is an Eligible Person

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

- you are not eligible for coverage under Medicare, TRICARE, or similar federal programs;
- you are not eligible for employer-sponsored group coverage or similar coverage; AND
- you reside in Rhode Island.

For the purpose of coverage under this *agreement*, only you can be considered eligible to enroll.

2.2 When Your Coverage Begins

When First Eligible

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

Under this *agreement,* the renewal date is October 1, 2013. This *agreement* will automatically renew on the renewal date (October 1, 2013) as long as your membership fees are paid. The only exception would be if one of the events from Section 2.4 - When Your Coverage Ends applies.

We accept new *subscribers* in accordance with Rhode Island General Law §27-18.5-3.

Coverage for Members who are Hospitalized on their Effective Date

If you are in the *hospital* on your effective date of coverage, health care services related to such hospitalization are covered as long as: (a) you notify us of your hospitalization within forty-eight (48) hours of the effective date, or as soon as is reasonably possible; and (b) *covered health care services* are received in accordance with the terms, conditions, exclusions and limitations of this *agreement.* As always, *benefits* paid in such situations are subject to the Coordination of benefits provisions described in Section 6.0.

2.3 When Your Coverage Ends

When We End This Agreement

This *agreement* will end automatically:

- on the date membership fees due 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;
- if we cease to offer this type of coverage, per the rights and limitations of Rhode Island General Law §27-18.5-4.
- the date fraud is identified. Fraud includes, but is not limited to, misuse of your identification card (ID card) and any misrepresentation made by you, or on your behalf, that affects your coverage. Fraud may result in retroactive termination. You will be responsible for all costs incurred by Blue Cross & Blue Shield of Rhode Island due to the fraud. Blue Cross & Blue Shield of Rhode Island may decline reinstatement under your Plans for Individuals & Families coverage. We may decline enrollment in any other coverages we offer that may become available in the future, as well;
- the date abuse or disregard for *provider* protocols and policies is identified by us. If after making a reasonable effort physicians are unable to establish or keep a satisfactory relationship with a *member*, coverage may be ended after thirty-one (31) days' written notice. Examples of unsatisfactory physician and patient relationships include:
  - abusive or disruptive behavior in a physician's office;
  - repeated refusals by a *member* to accept procedures or treatment recommended by a physician; and
  - impairing the ability of the physician to provide care.

When You End This Agreement

You may end this *agreement* by telling us in writing that you want to end coverage. We must get your notice to end this *agreement* at least five (5) working days before the requested date of cancellation. If we do not receive your notice within this five (5) working day period, you must pay another month's family membership fees. Requests for retroactive cancellations will NOT be allowed.

HIPAA certificate of creditable coverage

When your coverage ends, we will send to you a Health Insurance Portability and Accountability Act (HIPAA) certificate of creditable coverage to provide evidence of your prior health coverage. The information in the certificate lets your new health plan know how long you have had coverage, so you can receive credit for it. This information may help you reduce a pre-existing condition exclusion period, obtain a special enrollment under a new plan, or get certain types of individual health coverage even if you have a health condition.

We will also send to you a HIPAA certificate of creditable coverage upon request.

Reinstatement

We may reinstate coverage under this *agreement* if you:

- send an appeal in writing to us and we approve the appeal; and
- pay any required premiums within forty-five (45) days of the premium due date.

Required premiums include any overdue premiums and any premiums currently billed.

2.5 Continuation of Coverage

Extended Benefits

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

If you are disabled on the termination date of this agreement, your benefits will be temporarily extended for any continuous loss which commenced while the *agreement* was in force. The services provided under this benefit are subject to all terms, conditions, limitations and exclusions listed in this agreement, and the care you receive must relate to or arise out of the disability you had on the day this *agreement* ended.

The extension of benefits will cease upon the earliest of the following events:
- the continuous disability ends; or
- twelve (12) months from the termination date; or
- payment of the *maximum benefits* under this *agreement* has been met.

Extended benefits apply ONLY to the *subscriber* who is disabled. If you want to receive coverage for continued care when this *agreement* 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 as described in Section 7.0.

3.0 COVERED HEALTH CARE SERVICES

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

We only cover a service listed in this *agreement* if it is *medically necessary*. We review medical necessity in accordance with our medical policies and related guidelines. The term *medically necessary* is defined in Section 8.0 - Glossary. It does not include all medically appropriate services.

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

- as an *inpatient*;
- as an *outpatient*;
- in your home;
- in a *doctor's* office; or
- from a pharmacy.

Also coverage differs depending on whether:

- the health care *provider* is a *network provider* or *non-network provider;*
- *deductibles*, *copayments,* or *maximum benefit* apply;
- you have reached your *calendar year maximum out-of-pocket expense*;
- there are any exclusions from coverage that apply; or
- our *allowance* for a *covered health care service* is less than the amount of your *copayment* and *deductible* (if any). In this case, you will be responsible to pay up to our *allowance* when services are rendered by a *network provider*.

Please see the Summary of Benefits at the front of this *agreement* to determine the *benefit limits* and amount that you pay for the *covered health care services* listed below.

3.1 Ambulance Services

Ground Ambulance

In accordance with Rhode Island General Law § 27-20-55, ground ambulance services are covered up to the *benefit limits* and level of coverage listed in the Summary of Benefits.

Local professional or municipal ground ambulance services are covered when it is *medically necessary* to use these services, rather than any other form of transportation, to these places:

- to the closest available *hospital* for an *inpatient* admission;
- from a *hospital* to home or to a skilled nursing facility or to a rehabilitation facility after being discharged as an *inpatient;*
- to the closest available *hospital* emergency room immediately in an *emergency*;
- to and from a *hospital* for *medically necessary* services not available in the facility where you are an *inpatient*; or
- from a physician's office to a skilled nursing facility.

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

Related Exclusion

This *agreement* does NOT cover ground ambulance transportation to a physician's office.

Air and Water Ambulance

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

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

Water ambulance means transportation by a boat. The boat must be specially designed and equipped for transporting the sick or injured. It must also have such other safety and lifesaving equipment per state or local regulation.

Use of an air or water ambulance is *medically necessary* when the time needed to move a patient by land, or the instability of transportation by land, may threaten a patient's condition or survival. It is also *medically necessary* if the proper equipment needed to treat the patient is not available on a ground ambulance.

The patient must be transported for treatment to the nearest facility that can provide a level of care for the patient's illness. It must have available the type of physician or physician specialist needed to treat the patient's condition.

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

Related Exclusions

This *agreement* does NOT provide coverage for:

- air or water ambulance transportation unless the destination is an acute care *hospital* (some examples of non-covered air or water ambulance services include transport to a physician's office, nursing facility, or a patient's home); and
- transport from cruise ships when not in United States waters.

3.2 Behavioral Health Services

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

For the purposes of this *agreement* and as defined in Rhode Island General Law §27-38.2-2, mental illness means:

- Any mental disorder and substance abuse disorder that is listed in the most recent revised publication or the most updated volume of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICO) published by the World Health Organization and that substantially limits the life activities of the person with the illness;
- Substance abuse does not include addiction to or abuse of tobacco and/or caffeine;
- Mental disorders do not include mental retardation, learning disorders, motor skills disorders, communication disorders, and "V" codes as defined in DSM/IV Diagnostic Criteria published by the American Psychiatric Association.

Mental disorders are covered under Section A. **Mental Health Services**. Substance abuse disorders are covered under Section B. **Chemical Dependency Treatment**.

A. Mental Health Services

Inpatient

If you are an *inpatient* in a *general* or *specialty hospital* for mental health services, we cover *medically necessary hospital services* and the services of an attending physician. See Section 3.20 -– *Inpatient Hospital Services* for additional information.

Outpatient/ Intermediate Care Services

We cover *outpatient* services for the treatment of mental health disorders for individuals covered under this *agreement.*

Intermediate Care Services are facility based *outpatient programs* used as a step down from a higher level of care or a step-up from standard *outpatient* care. *Preauthorization* is recommended for intermediate care services.

We cover the following *medically necessary* mental health Intermediate Care Services:

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

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

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

  The program requires the health care *provider* to render a minimum of six (6) contact hours per week.

- **Child and Family Intensive Treatment (CFIT)** – We cover child and family intensive treatment services that are approved by us and meet our criteria for participation. CFIT is a facility based mental health care *program*. The *program* is primarily based in the home for qualifying children with moderate to severe psychiatric conditions. CFIT services must consist of, but are not limited to:
  - individual, family, and group counseling;

- medication consultation and management; and
- case management coordination with a school, state agency, *outpatient providers*, or physicians.

The *program* requires the health care *provider* to render a minimum of six (6) contact hours per week. CFIT benefits are available only for covered dependent children under the age of nineteen (19).

In a Provider's Office/In your Home
We cover the following *outpatient* mental health specialists:
- Psychiatrists;
- Licensed clinical psychologists;
- Clinical social workers (licensed or certified at the independent practice level);
- Licensed nurse clinicians (with a masters degree in nursing and certification by the ANA as a clinical specialist in psychiatric and mental health nursing);
- Licensed mental health counselor; AND
- Licensed marriage and family therapists.

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

Covered mental health services include *medically necessary* individual psychotherapy, group psychotherapy, and family therapy when rendered by a mental health specialist, as listed above.

We cover *outpatient* medication visits as an office visit when rendered by a psychiatrist or a clinical nurse specialist in behavioral health. See Section 3.23 – Office Visits.

This *agreement* provides coverage for services provided in a *provider's* office, in your home, and for *outpatient* medication visits. The amount that you pay for these office visits differs depending on whether the service is the first, second, or subsequent office visit in a *calendar year*. This limit applies to all office visits, except chiropractic office visits, preventive office visits and an oral (dental) examination. See the Summary of Benefits for *benefit limits* and your *copayment* amount.

For prescription drug coverage, see Section 3.27 - Prescription Drugs and Diabetic Equipment/Supplies. See the Summary of Pharmacy Benefits for benefit limits and the amount that you pay.

Electroconvulsive Therapy
We cover electroconvulsive therapy (ECT) services when performed and billed by a psychiatrist. We cover anesthesia services when rendered by an anesthesiologist. See Section 3.33 Surgery Services - Anesthesia Services.

Related Exclusions

This *agreement* does NOT cover the following mental health services:

- Recreation therapy, non-medical self-care, or self-help training;
- Mental health residential treatment programs (including eating disorder residential treatment programs) and mental health services performed in a residential treatment facility or in the portion of a *hospital,* or any *inpatient* facility, used for residential treatment purposes. We review the program, *hospital* or *inpatient* facility and the specific services provided to decide whether a program, *hospital* or *inpatient* facility meets our medical guidelines and criteria;
- Telephone consultations (See Section 4.15);
- Therapeutic recreation programs or wilderness programs;
- Services provided in any covered *program* that are reviewed by us and we decide are recreation therapy programs, and wilderness programs, or non-clinical services.

This *agreement* does NOT cover mental health services when:

- the *provider* does NOT meet the eligibility and/or credentialing requirements; or
- the *program* is not approved by us.

This *agreement* does NOT cover treatment at facilities that are not approved and/or licensed by the state in which the facility is located. See Section 4.5 for Services Provided by Facilities We Have Not Approved and Section 4.7 for Services Performed by People/Facilities Who Are Not Legally Qualified or Licensed.

For benefit information regarding coverage of *chemical dependency* in a *network hospital, chemical dependency treatment facility,* or a community residential facility see Section B. **Chemical Dependency Treatment**, below.

B. Chemical Dependency Treatment

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

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

- The *provider* must be licensed under the laws of the State of Rhode Island or by the state in which the facility is located as a *hospital,* a *chemical dependency treatment facility*, or a community residential facility for *chemical dependency* treatment; AND
- The *provider* must sign an *agreement* to provide covered *chemical dependency* services.

Related Exclusions

This a*greement* does NOT cover *chemical dependency* services provided in any covered *program* that are reviewed by us and we decide are recreation therapy programs, wilderness programs, or non-clinical services. We review the program, *hospital* or *inpatient* facility and the specific services provided to decide whether a program, *hospital* or *inpatient* facility meets our medical guidelines and criteria.

This *agreement* does NOT cover *chemical dependency* treatment when:

- the *provider* does NOT meet the eligibility and/or credentialing requirements; or
- the *program* is not approved by us.

This *agreement* does NOT cover treatment at facilities that are not approved and/or licensed by the state in which the facility is located. See Section 4.5 for Services Provided by Facilities We Have Not Approved and Section 4.7 for Services Performed by People/Facilities Who Are Not Legally Qualified or Licensed.

Inpatient/ Chemical Dependency Treatment Facility

We cover the following *inpatient chemical dependency* services:

- *Inpatient* detoxification as shown in the Summary of Medical Benefits.
- Acute Rehabilitation or Residential treatment as shown in the Summary of Medical Benefits.

Outpatient/Chemical Dependency Treatment Facility Intermediate Care Services

We cover *outpatient* services for the treatment of *chemical dependency* for individuals and family *members* covered under this *agreement.* The services must be rendered *outpatient* in a *hospital*, a *chemical dependency treatment facility*, or a state-licensed *provider/program* that we have approved.

Intermediate Care Services are facility based *outpatient programs* used as a step down from a higher level of care or a step-up from standard *outpatient* care. *Preauthorization* is recommended for intermediate care services.

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

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

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

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

  The program requires the health care *provider* to render a minimum of six (6) contact hours per week.

- **Child and Family Intensive Treatment (CFIT)** – We cover child and family intensive treatment services that are approved by us and meet our criteria for participation. CFIT is a facility based *chemical dependency* abuse health care *program*. The *program* is primarily based in the home for qualifying children with moderate to severe substance abuse conditions. CFIT services must consist of, but are not limited to:
  - individual, family, and group counseling;
  - medication consultation and management; and
  - case management coordination with a school, state agency, *outpatient providers*, and physicians.

  The program requires the health care *provider* to render a minimum of six (6) contact hours per week. CFIT benefits are available only for covered dependent children under the age of nineteen (19).

In a Provider's Office/In your Home
We cover services for the treatment of *chemical dependency* for individuals and family *members* covered under this *agreement.* The services may be rendered in a *provider's* office or in your home.

This *agreement* provides coverage for services provided in a *provider's* office or in your home. The amount that you pay for these office visits differs depending on whether the service is the first, second, or subsequent office visit in a *calendar year*. This limit applies to all office visits, except chiropractic office visits, preventive office visits, and an oral (dental) examination. See the Summary of Benefits for *benefit limits* and your *copayment* amount.

Related Exclusions

This *agreement* does NOT cover methadone clinics and treatments. See Section 4.5 - Services Provided By Facilities We Have Not Approved and Section 4.7 - Services Performed by People/Facilities Who Are Not Legally Qualified or Licensed.

3.3 Cardiac Rehabilitation

Outpatient

We cover *medically necessary* visits in a cardiac rehabilitation *program*. See the Summary of Medical Benefits for *benefit limits* and the amount that you pay.

3.4 Chiropractic Medicine

We cover *medically necessary* chiropractic visits up to the *benefit* limit and level of coverage as shown in the Summary of Medical Benefits. The *benefit limit* applies to any visit for the purposes of chiropractic treatment or diagnosis. We cover those selected lab tests and x-rays that may be ordered by a chiropractic physician according to relevant sections of Rhode Island General Law.

For information about medical equipment and supplies, see Section 3.8 - Durable Medical Equipment, Medical Supplies, Diabetic Supplies, Enteral Formula or Food, and Prosthetic Devices.

Related Exclusions

This *agreement* does NOT cover:

- massage therapy, aqua therapy, maintenance therapy, and aromatherapy;
- therapies, procedures, and services for the purpose of relieving stress;
- pillows;
- x-rays read by a chiropractic physician; and
- chiropractic services received in your home.

3.5 Contraceptive Drugs and Devices

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

- surgical insertion, removal and removal with reinsertion of contraceptive implants. Contraceptive implants are included in our *allowance* for the surgical insertion/reinsertion procedure. See Section 3.33 Surgery Services for how we cover surgical services.
- surgical implantation and removal of intrauterine device (IUD). The IUD is included in our *allowance* for the surgical implantation procedure. See Section 3.33 Surgery Services for how we cover surgical services.
- diaphragms supplied in a *doctor's* office are covered as a medical supply and subject to the level of coverage for medical equipment, medical supplies, and prosthetic devices received as an *outpatient*. See Section 3.8 Durable Medical Equipment, Medical Supplies, Diabetic Supplies, Enteral Formula or Food, and Prosthetic Devices.
- injectable contraceptive prescription drugs supplied and administered by a *doctor* are covered as an injectable prescription drug dispensed and administered by a licensed health care *provider* (other than a pharmacist). See Section 3.27 Prescription Drugs Dispensed and Administered by A Licensed Health Care Provider (Other Than a Pharmacy).
- prescribed oral contraceptives, contraceptive patches, diaphragms, and injectable contraceptive prescription drugs purchased at a *network pharmacy* are covered as a prescription drug purchased at a pharmacy. See Section 3.27 Prescription Drugs and the Summary of Pharmacy Benefits.

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

3.6 Dental Care

Hospital Emergency Room

Accident includes an accidental injury to your *sound natural teeth*. Accidental injuries are those caused by unexpected and unintentional means. We cover the *hospital* or emergency room services and the *doctor's* services. We cover the treatment in an emergency room for an accidental injury to your *sound natural teeth* or any facial fractures (or both) if the injury itself is the direct cause (independent of disease or bodily injury).

The amount that you pay for a covered hospital emergency room visit differs depending on whether the service is the first, second, or subsequent hospital emergency room visit in a *calendar year*. See the Summary of Benefits for *benefit limits* and your *copayment.*amount.

In an Office

If you receive the m*edically necessary* services due to an accidental injury to your *sound natural teeth* in a *doctor*/dentist's office, you are responsible for any applicable office visit *copayment.* See the Summary of Medical Benefits for details.

The amount that you pay for covered office visits differs depending on whether the service is the first, second or subsequent office visit in a *calendar year*. See the Summary of Benefits for *benefit limits* and your *copayment* amount.

Medically necessary services are covered when received within seventy-two (72) hours of an accidental injury to your *sound natural teeth.* The following services are covered:

- Extraction of teeth needed to avoid infection of teeth damaged in the injury;
- Suturing;
- Reimplanting and stabilization of dislodged teeth;
- Repositioning and stabilization of partly dislodged teeth; and
- Dental x-rays.

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

Related Exclusions

This *agreement* does NOT cover:

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

Services Provided in Connection with a Dental Service

Hospital services and *free-standing ambulatory surgi-center* services provided in connection with a dental service are covered when:

- the use of the hospital or free-standing ambulatory surgi-center is medically necessary; and
- the setting in which the service received is determined to be appropriate.

Preauthorization is recommended for this service.

Anesthesia services when rendered at a *hospital* or *free-standing ambulatory surgi-center* in connection with a dental service are covered when:

- the use of the hospital or free-standing ambulatory surgi-center is medically necessary; and
- the setting in which the service received is determined to be appropriate.

Preauthorization is recommended for this service**.** The dental services will remain non-covered. See Section 4.17.

Preventive Dental Services

We cover one (1) cleaning per and one (1) set of bitewing x-rays per *calendar year*.

3.7 Dialysis Services

Inpatient

Inpatient dialysis services are covered as a *hospital service*. See Section 8.0 - definition of *hospital services.*

Outpatient

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

In Your Home

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

Related Exclusions

If you receive dialysis services in your home, this *agreement* does NOT cover:

- installing or modifying of electric power, water and sanitary disposal or *charges* for these services;
- moving expenses for relocating the machine;
- installation expenses not necessary to operate the machine; or
- training you or *members* of your family in the operation of the machine.

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

3.8 Durable Medical Equipment, Medical Supplies, Diabetic Supplies, Enteral Formula or Food, & Prosthetic Devices

We cover *medically necessary* durable *medical equipment*, *medical supplies,* and *prosthetic devices* that meet the minimum specifications.

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

DURABLE MEDICAL EQUIPMENT is equipment (and supplies necessary for the effective use of equipment) which:

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose;
- is not useful to a person in the absence of an illness or injury; and
- is for use in the home.

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

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

Inpatient
Inpatient medically necessary durable medical equipment, *medical supplies*, diabetic equipment/supplies, enteral formula or food, and prosthetic devices you receive as an *inpatient,* when provided and billed for by the *hospital* where you are an *inpatient,* are covered as a *hospital service*. See Section 8.0 for the definition of *hospital services.*

When you are prescribed a *medically necessary prosthetic device* as an *inpatient* and it is billed by a *provider* other than the *hospital* where you are an *inpatient*, the *benefit limits* and level of coverage for Medical Equipment, Medical Supplies, and Prosthetic Devices - Outpatient will apply, as shown in the Summary of Medical Benefits.

Outpatient/In Your Home
See the Summary of Medical Benefits for *benefit limits* and the amount that you pay. We will cover the following *durable medical equipment*, *medical supplies*, diabetic equipment/supplies, enteral formula or food, and *prosthetic devices* subject to our guidelines.

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

Preauthorization is recommended for certain items. Repairs and supplies to rental equipment are included in our rental *allowance*. *Preauthorization* is recommended for replacement and repairs of purchased *durable medical equipment*.

We will cover the following *durable medical equipment* subject to our guidelines:
- Wheelchairs, hospital beds, and other *durable medical equipment* used only for medical treatment;
- Replacement of purchased equipment which is needed due to a change in your medical condition.

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

- Diaphragms supplied in a *doctor's* office; and
- Respiratory therapy equipment solutions.

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

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

- therapeutic/molded shoes for the prevention of amputation are covered for the treatment of diabetes; our *allowance* for molded shoes includes the initial inserts. Additional *medically necessary* inserts for custom-molded shoes are covered; and
- blood glucose monitors, blood glucose monitors for the legally blind, external insulin infusion pumps and appurtenances thereto, insulin infusion devices and injection aids for the treatment of insulin treated diabetes, non-insulin treated diabetes and gestational diabetes; and
- insulin needles and syringes when dispensed for use with insulin, test strips for glucose monitors and/or visual reading, cartridges for the legally blind, and infusion sets for external insulin pumps for the treatment of insulin treated diabetes, non-insulin treated diabetes, and gestational diabetes.

See the Summary of Benefits for *benefit limits* and the amount that you pay.

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

Some diabetic equipment and supplies can be bought at a *network* pharmacy. When bought at a *network* pharmacy, the covered diabetic equipment and supplies are subject to the *benefit limits* shown in the Summary of Pharmacy Benefits. See Section 3.27 - Prescription Drugs.

Prosthetic Devices
This *agreement* provides coverage per Rhode Island General Law. We will cover the following *prosthetic devices* subject to our guidelines:

- Prosthetic appliances such as artificial limbs, breasts, larynxes and eyes, including the replacement or adjustment of these appliances (replacement of a covered device will be allowed only if there is a change in your medical condition or if the device is not functional, no longer under warranty and cannot be repaired);
- Devices, accessories, batteries and supplies necessary for attachment to and operation of *prosthetic devices*;
- Orthopedic braces (except corrective shoes and orthotic devices used in connection with footwear); and
- Initial and subsequent *prosthetic devices* following a mastectomy and following an order of a physician or surgeon.

This *agreement* provides benefits for mastectomy-related prosthetics in accordance with the Women's Health and Cancer Rights Act of 1998 and Rhode Island General Laws 27-20-29 et seq. See Section 3.33 -Surgery Services – Mastectomy.

Related Exclusions

Items typically found in the home that do not need a prescription and are easily obtainable such as, but not limited to, adhesive bandages, elastic bandages, gauze pads, and alcohol swabs are NOT covered under this *agreement.*

This *agreement* does not cover *durable medical equipment* and *medical supplies* prescribed primarily for the convenience of the *member* or the *member's* family, including but not limited to, duplicate *durable medical equipment* or *medical supplies* for use in multiple locations or any *durable medical equipment* or *medical supplies* used primarily to assist a caregiver.

This *agreement* does NOT cover *durable medical equipment* that does not directly improve the function of the *member*.

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

This *agreement* does NOT cover pillows or batteries, except when used for the operation of a covered prosthetic device, or items whose sole function is to improve the quality of life or mental well being. See Section 4.27 for a list of personal appearance and service items NOT covered by this *agreement.*

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

Automated External Defibrillators (AED) are not covered under this *agreement*.

Enteral formulas or food (enteral nutrition)

Enteral formula or food is nutrition that is absorbed through the intestinal tract, whether delivered through a tube for feeding or taken orally. The amount that you pay differs depending on whether the enteral formula or food is the sole source of nutrition delivered through a feeding tube or taken orally.

This *agreement* provides coverage for enteral formula and supplies to administer enteral formula when it is delivered through a feeding tube and is the sole source of nutrition. See the Summary of Medical Benefits for the amount that you pay.

In accordance with Rhode Island General Law §27-20-56, this *agreement* covers *medically necessary* enteral formula taken orally for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, chronic intestinal

pseudo obstruction, and inherited diseases of amino acids and organic acids. Enteral formula is covered when a *doctor* has issued a written order and must be for home use. Also, food products modified to be low protein are covered for the treatment of inherited diseases of amino acids and organic acids. *Preauthorization* is recommended.

We will provide coverage for enteral formula up to the *maximum benefit.* You are responsible for paying the full amount due to the *provider.* If the full amount due to the *provider* is more than the *maximum benefit*, you are responsible for paying any difference. See Section 7.1 - How to File a Claim. We will reimburse the lesser of the *provider's charges* or the *maximum benefit* amount shown in the Summary of Medical Benefits. The *benefit limit* and level of coverage will apply as shown in the Summary of Medical Benefits.

Related Exclusions

This *agreement* does not provide coverage for enteral formula taken orally without a written order from the *doctor* and unless for the treatment of the conditions listed above. This *agreement* does not cover enteral formula taken orally unless for home use. Modified low protein food products are not covered unless for the treatment of the conditions listed above.

Hair Prosthetics (Wigs)

In accordance with Rhode Island General Law § 27-20-54, hair prosthetics (wigs) worn for hair loss suffered as a result of cancer treatment are covered up to the *maximum benefit* listed in the Summary of Medical Benefits.

We will provide coverage up to the *maximum benefit*. You are responsible for paying the full amount due to the *provider*. If the full amount due to the *provider* is more than the *maximum benefit*, you are responsible for paying any difference. See Section 7.1 – How to File a Claim. We will reimburse the lesser of the *provider's charges* or the *maximum benefit* amount shown in the Summary of Medical Benefits.

Related Exclusions

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

3.9 Early Intervention Services (EIS)

In accordance with Rhode Island General Law §27-20-50, this *agreement* provides coverage for Early Intervention Service. Early Intervention Services are educational, developmental, health, and social services provided to children from birth to 36 months. The children must have been certified by the Rhode Island Department of Human Services to enroll in an approved Early Intervention Services *program.* Services must be provided by a licensed Early Intervention *provider* and rendered to a Rhode Island resident. We cover Early Intervention Services as defined by the Rhode Island Department of Human Services including, but not limited to, the following:

- speech and language therapy;

- physical and occupational therapy;
- evaluation;
- case management;
- nutrition;
- service plan development and review;
- nursing services; and
- assistive technology services and devices.

See the Summary of Medical Benefits for the *maximum benefit* limit and the amount that you pay.

Early Intervention Services will only be covered if the *subscriber* is a child.

Related Exclusions

This *agreement* does NOT cover early intervention services when the services:

- are provided by a non-licensed early intervention *provider* ;or
- the services are rendered to a non-Rhode Island resident.

3.10 Education

Medically necessary asthma education sessions are covered when the service is prescribed by a physician and performed by a certified asthma educator. The asthma education session can be rendered in a *doctor's* office, *outpatient* department of a *hospital*, or in a *hospital* based clinic.

Other asthma related *covered health care services* including, but not limited to, office visits rendered by a *provider* (other than a certified asthma educator), medical equipment and supplies, and prescription drugs are subject to the benefit rules that apply to the specific services. For information about office visits, see Section 3.23 - Office Visits. For medical equipment and supplies, see Section 3.8 -– Durable Medical Equipment, Medical Supplies, Diabetic Supplies and Prosthetic Devices. For prescription drugs, see Section 3.27 - Prescription Drugs and the Summary of Pharmacy Benefits. See the Summary of Benefits for *benefit limits* and the amount that you pay.

3.11 Experimental/Investigational Services

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

Related Exclusions

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

Treatments, procedures, facilities, equipment, drugs, devices, supplies, or services will be recognized as having been proven effective in clinical medicine only if one of the following apply:

- Final approval for the use of a specific service for a specific condition from the appropriate governmental regulatory body; OR
- Demonstrated, reliable evidence based upon an entry in at least one of the three standard reference compendia (shown in subsection 4 (c) of this Section 3.11); OR
- Sound scientific studies published in authoritative, peer reviewed medical journals that:
  - show statistically significant outcomes about the effectiveness of the service, and
  - permit a consensus of opinion that the service improves the *member's* net health outcome, and
  - show it is as beneficial as any established alternatives, and
  - show that the improvement is attainable outside the *investigational* setting; OR
- The determination by an expert medical consultant retained by us, for the purpose of reviewing a particular service, that the service is not experimental/investigational for that particular member's case.

A service is considered experimental/investigational, if one or more of the following circumstances are true:

- The service is the subject of ongoing Phase I or Phase II clinical trial or is the experimental arm of Phase III clinical trial or is under study to determine the maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
- The prevailing opinion among experts about the service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- The current belief in the pertinent specialty of the medical profession in the United States is that the service or supply should not be used for the diagnosis or indications being requested outside of clinical trials or other research settings because it requires further evaluation for that diagnosis or indications. We will determine the applicability of this criterion based on:
  - Published reports in authoritative, peer-reviewed medical literature; AND
  - Reports, publications, evaluations, and other sources published by government agencies, such as the National Institutes of Health, the FDA, and the Agency for Healthcare Research and Quality; or
- If the benefit in question is a drug, a device, or other supply that is subject to approval by the FDA, at least one of the following criteria will apply:
  - it has not received FDA approval; or
  - it has limited FDA approval under regulations such as Treatment Investigational New Drugs; or

- it has FDA approval but the indication for the drug or device, or the dosage, is not an accepted off-label use. We will judge this criterion through review of reports published in authoritative peer-reviewed United States medical literature OR entries in one or more of the following drug compendia:
    i. The AMA Drug Evaluations;
    ii. The American Hospital Formulary Service Drug Information;
    iii. The U.S. Pharmacopoeia Dispensing Information; or

- The Institutional Review Board (IRB) of the provider of the service or supply acknowledges that use of it is experimental/investigational and is subject to the approval of the IRB; or
- The provider IRB requires the patient (or parent or guardian) to give an informed consent for the service or supply that states the service or supply is experimental/investigational, or federal law requires such a consent; or
- The research protocols related to the requested service or supply state or show the service or supply is experimental/investigational.

We will make a determination whether a service is *experimental/investigational*. If you disagree with our determination, you have the right to appeal or to take legal action as described in Section 7.0.

3.12 Hearing Services

Hearing exams
Medically necessary hearing exams are covered. Audiologists may perform a hearing test.

Hearing tests (diagnostic)
Diagnostic hearing tests (such as audiometric hearing tests) are covered under this *agreement*.

Hearing Aid
This *agreement* provides hearing aid coverage, in accordance with Rhode Island General Law § 27-20-46, for covered *members* up to the *maximum benefit limit* listed in the Summary of Medical Benefits.

We will provide coverage up to the maximum benefit. You are responsible for paying the full amount due to the *provider.* If the full amount due to the *provider* is more than the *maximum benefit*, you are responsible for paying any difference. See Section 7.1 - How to File a Claim. We will reimburse the lesser of the *provider's charges* or the *maximum benefit* amount shown in the Summary of Medical Benefits.

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

3.13 Hemophilia Services

Outpatient/In a Doctor's Office

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

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

For information about coverage for prescription drugs, including, but not limited to clotting factor drugs, see Section 3.27 – Prescription Drugs.

3.14 Home Health Care

In Your Home

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

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

For information about *doctor* home and office visits see Section 3.23 - Office Visits. For home care equipment and supplies, see Section 3.8. For radiation therapy or chemotherapy services, see Section 3.29 - Radiation Therapy/Chemotherapy Services. For prescription drugs, see Section 3.27 – Prescription Drugs.

Related Exclusions

This *agreement* does NOT cover:

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

3.15 Hospice Care

Inpatient

If you have a terminal illness and you agree with your *doctor* not to continue with a curative treatment program, we cover *inpatient* hospice care admissions to an approved hospice care *provider*.

Related Exclusions

This *agreement* does NOT cover custodial care, respite care, day care, or care in a facility that is not approved by us. See Section 4.5 - Services Provided by Facilities We Have Not Approved.

In Your Home

If you have a terminal illness and you agree with your *doctor* not to continue with a curative treatment program, we cover some hospice care services provided by a hospice care *program,* such as*:*

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

For information about *doctor* home and office visits, see Section 3.23 - Office Visits. For hospice care equipment and supplies, see Section 3.8. For prescription drugs, see Section 3.27 - Prescription Drugs. See the Summary of Benefits for *benefit limits* and level of coverage for each section.

3.16 Hospital Emergency Room Services

We cover *hospital* emergency room services only for an *emergency*. See Section 8.0 for the definition of an *emergency*. If your condition needs immediate or urgent, but non-*emergency* care, contact your *doctor* or use an *urgent care center*.

If you have an accident or medical *emergency* that needs emergency room services and your first visit to the emergency room occurs within twenty-four (24) hours of the accident or onset of symptoms, we cover the *hospital* emergency room services and the *doctor's* services.

Bandages, crutches, canes, collars, and other supplies incidental to your treatment in the emergency room are covered as part of our *allowance* for the emergency room services.

When physician services are rendered in the emergency room, other than the emergency room physician examination, the amount that you pay is based on the type of service being rendered. For surgery services (including but not limited to sutures, fracture care, and other surgical procedures), see Section 3.33 - Surgery Services. For a specialist exam, see Section 3.23 -

Office Visits. For diagnostic imaging, lab, and machine tests, sees Section 3.8. See the Summary of Benefits for *benefit limits* and the amount that you pay for each type of service.

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

The amount that you pay for a covered hospital emergency room visit differs depending on whether the service is the first or subsequent hospital emergency room visit in a *calendar year*. See the Summary of Benefits for *benefit limits* and your *copayment* amount.

Related Exclusions

This *agreement* does NOT cover:

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

3.17 Human Leukocyte Antigen Testing

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

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

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

3.18 Infertility Services

Inpatient/Outpatient/In a Doctor's Office

In accordance with Rhode Island General Law §27-20-20, this *agreement* provides coverage for *medically necessary* services for the diagnosis and treatment of infertility for women between the ages of 25 and 42 years old. We cover donor gametes if provided through a *program*. We only cover these services if you are:

- married; (according to the statutes of the state in which you were married);
- unable to conceive or sustain a pregnancy during a one (1) year period; AND
- a presumably healthy individual.

Infertility services**,** including prescription drug coverage, are covered up to the *benefit limit* and level of coverage shown in the Summary of Benefits. Infertility prescription drug coverage is based on the route of administration and site of service. See Section 3.27 - Prescription Drugs for details. See the Summary of Pharmacy Benefits for *benefit limits* and the amount that you pay.

Related Exclusions

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

3.19 Infusion Therapy

Inpatient

Inpatient infusion therapy services are covered as a *hospital service*. See Section 8.0 - definition of *hospital services.*

Outpatient

If you receive infusion therapy services in a *hospital's outpatient* unit, we cover the use of the treatment room, related supplies, and solutions. For prescription drug coverage, see Section 3.27 – Prescription Drugs.

See the Summary of Benefits for *benefit limits* and the amount that you pay.

In a Doctor's Office

If you receive infusion therapy services in a *doctor's* office, we cover the related supplies and solutions. For prescription drug coverage, see Section 3.27 – Prescription drugs.

In Your Home

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

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

For information about *doctor* home and office visits see Section 3.23 - Office Visits. For home care equipment and supplies, see Section 3.8. For radiation therapy or chemotherapy services, see Section 3.29 - Radiation Therapy/Chemotherapy Services. For prescription drugs, see Section 3.27 – Prescription Drugs.

Related Exclusions

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

3.20 Inpatient Hospital Services

Inpatient - Semi-Private Room Charges/Days of Hospital Coverage

We cover inpatient *hospital services* in a ward or *semi-private room* in *a general hospital* for medical or surgical services.

Coverage for physical rehabilitation services received in *a specialty hospital* or in *a general hospital* is limited to the number of days shown in the Summary of Medical Benefits. *Preauthorization* is recommended for this service.

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

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

Related Exclusions

This *agreement* does NOT cover:

- extra *charges* for a private room; and
- the dental services that are performed with covered *hospital services* or with covered *free-standing ambulatory surgi-center* services (see Section 4.17 for a list of excluded dental services).

3.21 Inpatient Physician Hospital Visits

For coverage of surgeons, see Section 3.33 - Surgery Services.

If you are admitted to *a general hospital* as an *inpatient* for a medical condition, we cover the services of a *doctor* in charge of your medical care, up to one (1) visit per day.

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

If, while you are in the *hospital*, the attending *doctor* in charge of your care asks for the assistance of a *doctor* who has special skills and knowledge to diagnose your condition, we cover a consultation performed by a specialist. The transferring of a patient

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

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

3.22 Inpatient Rehabilitation Facility

Coverage for physical rehabilitation services received in *a specialty hospital* or in *a general hospital* is limited to the number of days shown in the Summary of Medical Benefits. *Preauthorization* is recommended for this service.

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

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

Related Exclusions

This *agreement* does NOT cover:

- extra *charges* for a private room.

3.23 Office Visits

We cover medically *necessary* office visits provided they are reasonable in number and in the scope of the services rendered for the following:

- office visits to personal physician;
- office visits to specialists;
- routine examinations;
- consultations;
- medication visits for outpatient mental illness; or
- office visits to oral and maxillofacial surgeons (OMS) for medical conditions.

The amount that you pay for these office visits differs depending on whether the service is the first, second, or subsequent office visit in a *calendar year*. This limit applies to all office visits, except chiropractic office visits, preventive office visits, and an oral (dental) examination. See the Summary of Benefits for *benefit limits* and your *copayment* amount.

See the Summary of Medical Benefits for *benefit limits* and the amount that you pay. For prescription drugs, see Section 3.27 – Prescription Drugs.

Hospital Based Clinic Visits
Other *covered health care services* provided by a clinic, such as physical therapy or occupational therapy, are subject to the benefit rules that apply to the specific service.

House Calls
We cover *doctor* visits in your home if you have a condition due to an injury or illness which:

- confines you to your home;
- requires special transportation; or
- requires the help of another person.

In a Doctor's Office
Our *allowance* for an office visit includes *medical supplies* provided as part of the office visit. See the Summary of Medical Benefits for *benefit limits* and the amount that you pay for each service.

When physician services are rendered in a *doctor's* office, other than an office visit examination, the amount that you pay is based on the type of service being rendered. For surgical services (including but not limited to sutures, fracture care, and other surgical procedures) see Section 3.33 Surgery Services. For diagnostic imaging, lab and machine tests see Section 3.34.

Obstetrical or Gynecological Care
You do not need *preauthorization* from us or from any other person (including a *personal physician*) in order to obtain access to obstetrical or gynecological care from a *network doctor* who specializes in obstetrics or gynecology. Your *doctor,* however, may be required to comply with certain procedures, including obtaining *preauthorization* for certain services. For a list of *network* physicians who specialize in obstetrics or gynecology, contact our Customer Service Department.
When physician services are rendered in a *doctor's* office, other than an office visit examination, the amount that you pay is based on the type of service being rendered. For surgical services (including but not limited to sutures, fracture care, and other surgical procedures) see Section 3.33 Surgery Services. For diagnostic imaging, lab, and machine tests see Section 3.34.

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

This *agreement* does NOT cover routine foot care including the treatment of corns, bunions (except capsular or bone surgery) calluses, the trimming of nails, the treatment of simple ingrown nails and other preventive hygienic procedures, except when performed to treat diabetic related nerve and circulation disorders of the feet.

This *agreement* does NOT cover the treatment of flat feet unless the treatment is surgical. Corrective or orthopedic shoes and orthotic devices used in connection with footwear are NOT covered unless for the treatment of diabetes. See Section 3.8, subsection - Diabetic Equipment/ Supplies.

3.24 Organ Transplants

We cover transplants for heart, heart-lung, lung, liver, small intestine-pancreas, kidney, cornea, small bowel, and bone marrow transplants.

Allogenic bone marrow transplant *covered health care services* include medical and surgical services for the matching participant donor and the recipient. However, Human Leukocyte Antigen testing is covered as indicated in the Summary of Medical Benefits, subject to certain conditions. For details see Section 3.17 - Human Leukocyte Antigen Testing.
Medically necessary high dose chemotherapy and radiation services related to autologous bone marrow transplantation is limited. See definition of *Experimental/Investigational* – Section 8.0.

To the extent that coverage for bone marrow or stem cell transplantation is more limited than the coverage required by "New Cancer Therapies", the applicable provisions of the Rhode Island Laws shall govern. See Section 8.0 for the definition of *experimental/ investigational* services.

The national transplant network program is called the Blue Distinction Centers for Transplants℠. For more information about the Blue Distinction Centers for Transplants℠ call our Case Management Department at 1-401-459-2273 or 1-888-727-2300 ext. 2273.

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

- obtaining donated organs (including removal from a cadaver);
- donor medical and surgical expenses related to obtaining the organ that are integral to the harvesting or directly related to the donation and limited to treatment occurring during the same stay as the harvesting and treatment received during standard post-operative care; and
- transportation of the organ from donor to the recipient.

The amount you pay for transplant services for the recipient and eligible donor is based on the type of service. For information about office visits see Section 3.23 - Office Visits. For surgical procedures see Section 3.33 - Surgery Services. For lab, radiology, and machine tests see Section 3.34 – Tests, Imaging, and Labs. See the Summary of Medical Benefits for *benefit limits*. For prescription drugs, see Section 3.27.

Related Exclusions

This *agreement* does NOT cover:

- services or supplies related to an excluded transplant procedure;
- medical services of the donor that are not directly related to the organ transplant;
- drives and related expenses to find a donor;
- services related to obtaining, storing, or other services performed for the potential future use of umbilical cord blood;
- noncadaveric small bowel transplants;
- services related to donor searches for allogenic bone marrow transplants; and
- the donation-related medical and surgical expenses of a donor when the recipient is NOT covered as a *member*.

3.25 Physical/Occupational Therapy

Physical and occupational therapy is covered only when:

- a program is implemented to restore the highest level of independent functioning in the most timely manner possible;
- physical or occupational therapy is received from a licensed physical or occupational therapist;
- physical or occupational therapy is ordered by a doctor;
- the therapy will result in significant, sustained measurable functional or anatomical improvement of your condition; and
- such improvement will not diminish with the removal of the therapeutic agent or environment.

Inpatient

Medically necessary inpatient physical or occupational therapy is covered as a *hospital service.* See Section 8.0.

Outpatient/In a Doctor's or Therapist's Office

We cover *medically necessary* physical and occupational therapy services. See the Summary of Medical Benefits for *benefit limits.*

In Your Home

This *agreement* does NOT cover physical or occupational therapy services received in your home unless received through a home care *program*. See Section 3.14 - Home Health Care.

Related Exclusions

This *agreement* does NOT cover:

- services rendered by a massage therapist.
- hippotherapy.

This *agreement* does NOT cover these services if another entity or agency which provides services for the health of school children or children with disabilities is responsible for such services under state or federal laws. (See generally, Title 16, Chapters 21, 24, 25 and 26 of the Rhode Island General Laws. See also applicable regulations about the health of school children and the special education of children with disabilities or similar rules set forth by federal law.)

3.26 Pregnancy Services and Nursery Care

Inpatient

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

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

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

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

See Section 3.23 - Office Visits for coverage of home and office visits.

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

Related Exclusions

This *agreement* does NOT cover, genetic screening, preimplantation genetic diagnosis (embryo screening), or parentage testing. This *agreement* does NOT cover amniocentesis or any other service used to determine the sex of an infant before it is born.

Treatment and services rendered to your newborn child, including inpatient nursery care, are NOT covered services under this *agreement*. Your newborn child is not an *eligible person* under this *agreement*.

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

The first office visit to diagnose pregnancy is not included in prenatal services. Office visits to an obstetrician or midwife that are not related to pregnancy are not included in prenatal services. Both are covered as an office visit. See Section 3.23 - Office Visits.

3.27 Prescription Drugs and Diabetic Equipment/Supplies

Definitions
The following definitions apply to this Section 3.27:

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

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

FORMULARY means the prescription drugs and dosage forms covered under this *agreement.* Some prescription drugs are not in the *formulary*. If a prescription drug is not in our *formulary*, then it is not covered under this *agreement*. A committee of local physicians and pharmacists, set up by us, develop the prescription drug *formulary* listing which is subject to periodic review and is subject to change. The committee decides the tier placement of drugs in the *formulary*, which determines the amount you will pay. To obtain coverage information for a specific prescription drug or to get a copy of the most current *formulary* listing, visit our Web site at BCBSRI.com. Or, you may call our Customer Service Department at (401) 459-5000 or 1-800-639-2227 for information.

LEGEND DRUG is a drug that federal law does not allow the dispensing of without a prescription.

NETWORK PHARMACY means any pharmacy that has an *agreement* to accept our *pharmacy allowance* for prescription drugs and diabetic equipment/supplies covered under this *agreement.* All other pharmacies are **NON-NETWORK PHARMACIES**. The one exception and for the purpose of *specialty prescription drugs,* only specialty pharmacies that have an *agreement* to accept our *pharmacy allowance* are *network pharmacies* and all others pharmacies are *non-network pharmacies.*

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

PRESCRIPTION DRUG DEDUCTIBLE means the total amount of covered prescription drug expenses that you must pay before we provide benefits for covered prescription drugs purchased at a *network* retail and mail order *pharmacy*. See the Summary of Pharmacy Benefits to determine the amount of the *prescription drug deductible*.

PRESCRIPTION DRUG PREAUTHORIZATION is the advance approval that must be obtained before we provide coverage for certain prescription drugs. *Prescription drug preauthorization* is not a guarantee of payment, as the process does not take benefit limits into account. The process for obtaining *prescription drug preauthorization* is described below.

You must ask the prescribing physician to request *prescription drug preauthorization* for certain preferred brand name and non-preferred brand name prescription drugs and certain specialty prescription drugs, if the specialty prescription drug is bought at a *network pharmacy*. If the specialty prescription drug is bought at a *non-network pharmacy*, *prescription drug preauthorization* is not required. For details see section **A. Pharmacy Program for Prescription Drugs and Diabetic Equipment/Supplies Purchased at a Pharmacy** listed below. Services for which *prescription drug preauthorization* is required are marked with a (+) symbol in the Summary of Pharmacy Benefits.

SITE OF SERVICE means, for the purposes of this a*greement*, the three types of pharmacies which include:
- retail pharmacies,
- specialty pharmacies, and
- mail order pharmacy.

SPECIALTY PRESCRIPTION DRUG is a type of prescription drug in our *formulary* that generally is identified by, but not limited to, features such as:
- being produced by DNA technology,
- treats chronic or long term disease,

- requires customized clinical monitoring and patient support, and
- needs special handling.

Generally, specialty pharmacies dispense *specialty prescription drugs*. Contact Customer Service for further details and information about *specialty prescription drugs* and specialty pharmacies. For the purposes of this *agreement*, we have designated certain prescribed prescription drugs in our *formulary* to be *specialty prescription drugs.* To obtain coverage information for any specific *specialty prescription drug* or to obtain a copy of the most current *formulary* listing, visit our Web site at BCBSRI.com. Or, you may call our Customer Service Department at (401) 459-5000 or 1-800-639-2227.

TYPE OF SERVICE means, for the purposes of this *agreement*, the two kinds of prescription drugs which are defined as:
- generic, preferred brand name, and non-preferred brand name prescription drugs; and
- *specialty prescription drugs.*

Overview
Prescription drugs and diabetic equipment and supplies bought at a pharmacy are administered by our Pharmacy Benefit Manager (PBM). Prescription drugs bought at a pharmacy are subject to the *benefit limits* and level of coverage shown in the Summary of Pharmacy Benefits. For details, see section **A. Pharmacy Program for Prescription Drugs and Diabetic Equipment/Supplies Purchased at a Pharmacy** listed below.

Generic, preferred brand name, and non-preferred brand name prescription drugs dispensed and administered by a licensed health care *provider* (other than a pharmacy) are subject to the *benefit limit* and level of coverage shown in the Summary of Medical Benefits. *Specialty prescription drugs* are not separately reimbursed when dispensed by a professional *provider* unless bought from a Specialty Pharmacy. For details, see section **B. Generic, Preferred Brand Name, or Non-Preferred Brand Name Prescription Drugs Dispensed and Administered by a Licensed Health Care *Provider* (other than a Pharmacy)** listed below.

A. Pharmacy Program for Prescription Drugs and Diabetic Equipment/Supplies Purchased at a Pharmacy

Introduction
This section provides coverage information for prescription drugs in our *formulary* generic, preferred brand name, and non-preferred brand name prescription drugs, *specialty prescription drugs* and diabetic equipment and supplies that are bought at a pharmacy. Prescription drugs must be identified as covered under this *agreement* in our *formulary* and dispensed per our *dispensing guidelines* in order to be covered.

Generic, preferred brand name, and non-preferred brand name prescription drugs may be dispensed at a retail pharmacy, a specialty pharmacy, a mail order pharmacy, or by a provider other than a pharmacy. *Specialty prescription drugs* must be dispensed at a specialty pharmacy or a *non-network pharmacy.* If a professional provider dispenses a *specialty prescription*

drug, it is not separately reimbursed unless obtained from a specialty pharmacy. The administration of the *specialty prescription drug* is covered.

For information about the administration of *specialty prescription drugs*, see Section 3.2 -Behavioral Health, Section 3.13 - Hemophilia Services, Section 3.14- Home Health Care, Section 3.18 -Infertility Services, Section 3.19- Infusion Therapy, Section 3.23- Office Visits, and Section 3.29- Chemotherapy Services.

If you are dispensed a *specialty prescription drug* from a Rhode Island *network provider,* the charge for the *specialty prescription drug* is not reimbursed and the Rhode Island *network provider* may not seek reimbursement from you. If you are dispensed a *specialty prescription drug* from a *non-network provider* or by a *provider* that participates with an out of state Blue Cross or Blue Shield plan, the charge for the *specialty prescription drug* is not reimbursed. You are liable to pay the charge for the *specialty prescription drug*.

Prescription drugs are reimbursed based on the *type of service* and the *site of service*. See the Summary of Pharmacy Benefits for *benefit limits* and the amount that you pay.

Coverage for prescription drugs is subject to the pharmacy program. The pharmacy program's *formulary* includes a four-tier *copayment* structure and requires *prescription drug preauthorization* for certain prescription drugs. It also includes dose optimization conditions. Each of these items is described in more detail below. Coverage is provided for prescription drugs bought at a pharmacy, per the terms, conditions, exclusions, and limitations of this *agreement.*

Four-Tier Copayment Structure
This prescription drug plan *formulary* has a four-tiered *copayment* structure.

First Tier: includes *formulary* low cost generic prescription drugs, which require the lowest *copayment.*

Second Tier: includes *formulary* high cost generic prescription drugs and preferred brand name prescription drugs, which require a higher *copayment*.

Third Tier: includes *formulary* non-preferred generic and non-preferred brand name drugs which require a higher *copayment* than the Second Tier.

Fourth Tier: includes *formulary specialty prescription drugs,* which require a *copayment.*

Our *formulary* lists generic, preferred brand name, and non-preferred brand name prescription drugs and *specialty prescription drugs* covered under this *agreement.* We decide which tier a drug will be placed into for *copayment* purposes. To check the tier placement of a prescription drug or to obtain a copy of the most current *formulary* listing, visit our Web site at BCBSRI.com. Or, you may call our Customer Service Department at (401) 459-5000 or 1-800-639-2227.

See the Summary of Pharmacy Benefits for *benefit limits* and the amount that you pay.

Mail Order Pharmacy
Maintenance and non-maintenance generic, preferred brand name, or non-preferred brand name prescription drugs and diabetic equipment and supplies may be bought from a *network* mail order pharmacy. The prescription is limited to the *benefit limit* and level of coverage shown in the Summary of Pharmacy Benefits. For mail order instructions, please call our Customer Service Department.

Covered Diabetic Equipment/Supplies
The following diabetic equipment and supplies can be bought at a *network pharmac*y:

- Glucometers;
- Test Strips;
- Lancet and Lancet Devices; and
- Miscellaneous Supplies (including calibration fluid).

See the Summary of Pharmacy Benefits for *benefit limits* and the amount that you pay.

Covered over- the- counter (OTC) drugs
Certain preventive over- the- counter (OTC) drugs when prescribed by a physician are covered. To obtain a specific list of the OTC drugs that are covered, call our Customer Service Department or visit our website at www.bcbsri.com.

Restricted Pharmacy
We may limit your selection of a pharmacy to one (1) *network pharmacy*. *Members* subject to this restriction are those members that have been prescribed prescriptions by multiple physicians and have had prescriptions filled at multiple pharmacies. Contact our Customer Service Department for more information.

How Covered Prescription Drugs and Diabetic Supplies/Equipment Are Paid
When you buy covered prescription drugs and diabetic equipment and supplies from a *network* pharmacy, you will be responsible for the *copayment* and *prescription drug deductible* (if any) shown in the Summary of Pharmacy Benefits at the time you buy the prescription drugs and diabetic equipment and supplies. Coverage is based on our *pharmacy allowance*.

This *agreement* does NOT cover generic, preferred brand name, and non-preferred brand name prescription drugs or diabetic equipment and supplies when bought at *non-network pharmacies*. If you buy generic, preferred brand name, and non-preferred brand name prescription drugs or diabetic equipment and supplies from *non-network pharmacies*, you will be responsible to pay the charge for the prescription drug or diabetic equipment and supplies at the time the prescription is filled.

If you buy s*pecialty prescription drugs* from a retail *network pharmacy* or a *non-network pharmacy*, you will be responsible to pay the charge for the *specialty prescription drug* at the time the prescription is filled. You may submit a *claim* to us and we will reimburse you directly. You will be responsible for the *copayment* shown in the Summary of Pharmacy Benefits and the difference between the *charge* and the *pharmacy allowance*. See Section 7.1 - How to File a *Claim*.

How to Obtain Prescription Drug Preauthorization

Prescription drug preauthorization is required for certain brand name prescription drugs and certain *specialty prescription drugs*. To obtain *prescription drug preauthorization*, the prescribing *provider* must submit a completed *prescription drug preauthorization* request form.

The prescribing *provider* may obtain a *prescription drug preauthorization* form by visiting our Web site at BCBSRI.com or calling the Physician and Provider Service Center. *Preauthorization* requests may be submitted in one of the following ways:

- By fax, submit the form to CVS Caremark at 1-888-836-0730;
- By phone, contact CVS Caremark at 1-800-294-5979;
- By mail, send the completed form to:

CVS Caremark Prior Authorization Center
1300 E. Campbell Road
Richardson, TX 75081

Prescription drugs that require *prescription drug preauthorization* will only be approved when our clinical guidelines are met. The guidelines are based upon clinically appropriate criteria that ensure that the prescription drug is appropriate and cost–effective for the illness, injury or condition for which it has been prescribed.

We will send to you written notification of the *prescription drug preauthorization* determination within two (2) business days of receipt of all medical documentation required to conduct the review, but not to exceed fourteen (14) calendar days from the receipt of the request.

Note: You may request an expedited review if the circumstances are an emergency. Due to the urgent nature of an expedited review, your prescribing *provider* must fax the completed form to 1-866-261-0453. If an expedited preauthorization review is received by us, we will respond to you with a determination within seventy two (72) hours following receipt of the request.

If you have not obtained *prescription drug preauthorization* before you pick up the prescription drug from the pharmacy for the first time, you can ask us to consider reimbursement later. To do this, you must follow the *prescription drug preauthorization* process described above and submit your request for review, along with a copy of your receipt, within fifteen (15) days of picking

up the prescription. If our clinical guidelines are met for the prescription drug, we will approve your claim to be reimbursed retroactively less the applicable *copayment* or *deductible*.

To obtain a list of the brand name prescription drugs and *specialty prescription drugs* that require *prescription drug preauthorization*, visit our Web site at BCBSRI.com or call our Customer Service Department at (401) 459-5000 or 1-800-639-2227.

If you are not satisfied with the *prescription drug preauthorization* determination, you can submit a Medical Appeal. See Section 7.3 for information on how to file a Medical Appeal.

How to Obtain Dose Optimization
Dose optimization is the most effective dose and measured quantity of a generic, preferred brand name, and non-preferred brand name prescription drug to be taken at one time. Under this *agreement*, certain generic, preferred brand name, and non-preferred brand name prescription drugs may NOT be covered if you are taking multiple daily doses of a prescription drug that is available to be taken once per day at a higher dose. To obtain a list of the prescription drugs subject to dose optimization, visit our Web Site at BCBSRI.com. Or, you may call our Customer Service Department at (401) 459-5000 or 1-800-639-2227.

When dose optimization applies, the *network pharmacy* will consult with your prescribing *provider* and with the prescribing *provider's* approval, the single daily dose of the prescription drug will be dispensed. If you choose to buy the multiple daily dose of the lower strength prescription drug, it will NOT be covered under this *agreement.*

If your prescribing provider deems it *medically necessary* that you continue to take multiple daily doses of a lower strength generic, preferred brand name, or non-preferred brand name prescription drug, *prescription drug preauthorization* is required and must be obtained before we provide coverage. To request *prescription drug preauthorization,* the prescribing *provider* must complete and submit a dose optimization authorization form. Coverage for multiple daily doses of a lower strength generic, preferred brand name, or non-preferred brand name prescription drug will only be approved when the dose optimization guidelines are met.

The prescribing *provider* may obtain a form by visiting our Web site at BCBSRI.com or calling the Physician and Provider Service Center. Requests may be submitted in one of the following ways:

- By fax, submit the form to CVS Caremark at 1-888-836-0730;
- By phone, contact CVS Caremark at 1-800-294-5979;
- By mail, send the completed form to:

CVS Caremark Prior Authorization Center
1300 E. Campbell Road

Richardson, TX 75081

We will send to you written notification of the determination within two (2) business days of receipt of all medical documentation required to conduct the review, but not to exceed fourteen (14) calendar days from the receipt of the request.

Note: You may request an expedited review if the circumstances are an emergency. Due to the urgent nature of an expedited review, your prescribing *provider* must fax the completed form to 1-866-261-0453. If an expedited preauthorization review is received by us, we will respond to you with a determination within seventy two (72) hours following receipt of the request.

Over-the-Counter (OTC) Options Program
This program allows an *eligible member* to buy specifically designated OTC drugs at no cost. To participate in this program, you must agree to use the alternative OTC drug instead of the prescription drug. The OTC drug must be bought at a *network* retail pharmacy. The monthly quantity is subject to the *benefit limits* shown in the Summary of Pharmacy Benefits. You may obtain a current list of the prescription drugs included in the OTC options program by visiting our Web site or calling our Customer Service Department.

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

- biological products for allergen immunotherapy;
- biological products for vaccinations;
- blood fractions;
- compound prescription drugs that are not made up of at least one *legend drug;*
- prescription drugs prescribed or dispensed outside of our *dispensing guidelines*;
- prescription drugs indicated as being not covered on our *formulary*;
- prescription drugs that have not proven effective according to the FDA;
- prescription drugs used for cosmetic purposes ;
- prescription drugs purchased in excess of the stated quantity limits;
- *experimental* prescription drugs (including those placed on notice of opportunity hearing status by the Federal Drug Efficacy Study Implementation (DESI);
- drugs you take or have given to you while you are a patient in a *hospital,* rest home, sanitarium, nursing home, home care *program*, or other institution that provides prescription drugs as part of its services or which operates its own facility for dispensing prescription drugs;
- non-medical substances (regardless of the reason prescribed, the intended use, or medical necessity);
- off-label use of prescription drugs (except as described in Section 3.11 *Experimental/Investigational* Services);

- over-the-counter (OTC) drugs even if prescribed, unless specifically listed as a *covered health care service* in this *agreement* (such as, OTC nicotine replacement therapy in accordance with Rhode Island General Law 27-20-53,or as part of our OTC Options Program, or PPACA);
- OTC drugs designated as covered under this *agreement* for which you do not have a written prescription from your physician;
- prescribed weight-loss drugs;
- replacement prescription drug products resulting from a lost, stolen, broken or destroyed prescription order or refill;
- support garments and other durable medical equipment;
- therapeutic devices and appliances, including hypodermic needles and syringes (except when used to administer insulin);
- sildenafil citrate (Viagra) or any therapeutic equivalents; OR
- Vitamins specifically listed as a *covered health care service* in this *agreement*.

We will NOT cover a prescription drug refill if the refill is:
- greater than the refill number authorized by your *doctor;*
- greater than the twelve (12) refills we authorize;
- limited by law; or
- re-filled more than a year from the date of the original prescription.

The following are NOT covered when purchased from a *non-network pharmacy*:
- generic, preferred brand name, or non-preferred brand name prescription drugs; and
- diabetic equipment and supplies.

The following are NOT covered when purchased from a mail order pharmacy:
- *specialty prescription drugs*; and
- nicotine replacement therapy.

Generic, preferred brand name, or non-preferred brand name prescription drugs and *specialty prescription drugs* are NOT covered when the required *prescription drug preauthorization* is not obtained.

Multiple daily doses of a generic, preferred brand name, or non-preferred brand name prescription drug are NOT covered when dose optimization conditions are not met.

Certain prescribed prescription drugs that have an over-the-counter equivalent (OTC) are NOT covered under this *agreement.* To obtain the list of OTC prescription drugs visit our Web site at BCBSRI.com or contact our Customer Service Department at (401) 459-5000 or 1-800-639-2227.

B. Generic, Preferred Brand Name, or Non-Preferred Brand Name Prescription Drugs Dispensed and Administered by a Licensed Health Care *Provider* (other than a Pharmacy)

Generic, preferred brand name, or non-preferred brand name prescription drugs we have approved that are dispensed and administered by a licensed health care *provider* (other than a pharmacy) are covered under this *agreement,* subject to the *copayment* and *deductible*(if any*)* shown in the Summary of Medical Benefits. The generic, preferred brand name, or non-preferred brand name prescription drug must be dispensed per our *dispensing guidelines* in order to be covered.

Inpatient

We cover *inpatient* drugs as a *hospital service*. See Section 8.0 – definition of *hospital services*.

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

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

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

Inhalation, Nasal, Ocular, Oral, Rectal Or Vaginal, Sublingual, Topical, And Transdermal Generic, Preferred Brand Name, or Non-Preferred Brand Name Prescription Drugs
The prescription drug is included in our *allowance* for the medical service being rendered. If the sole service is drug dispensing, the prescription drug is NOT covered.

Injected Generic, Preferred Brand Name, or Non-Preferred Brand Name Prescription Drugs
We use the term injected to include prescription drugs approved by us given by intra muscular or subcutaneous injection or in the case of a body cavity by instillation. See the Summary of Medical Benefits for *benefit limits* and the amount that you pay. See Section 3.28 Prevention and Early Detection Services for immunization and vaccination coverage information.

Infused Generic, Preferred Brand Name, or Non-Preferred Brand Name Prescription Drugs
We use the term infused to include those prescription drugs approved by us and administered into a vein or into an artery whether by mixing in fluids and administering intravenously or into an artery, direct injection, or by use of a pump that accesses the vein or artery. See the Summary of Medical Benefits for *benefit limits* and the amount that you pay.

Related Exclusions
Specialty prescription drugs are not separately reimbursed unless bought from a specialty pharmacy.

If you are dispensed a *specialty prescription drug* from a Rhode Island *network provider,* the charge for the *specialty prescription drug* is not reimbursed and the Rhode Island *network provider* may not seek reimbursement from you. If you are dispensed a *specialty prescription drug* from a *non-network provider* or by a *provider* that participates with an out of state Blue Cross or Blue Shield plan, the charge for the *specialty prescription drug* is not reimbursed and you are liable to pay the charge for the *specialty prescription drug*. Please contact our Customer Service Department at (401) 459-5000 or 1-800-639-2227 for further details.

Compound medications dispensed and administered by licensed health care *providers* (other than a pharmacy) that are not made up of at least one *legend drug* are NOT covered.

3.28 Preventive Care Services and Early Detection Services

In accordance with PPACA, this *agreement* provides coverage rendered to a *subscriber* for early detection services, preventive *care services,* and immunizations/vaccinations as set forth in the guidelines of the following resources:

- services that have an A or B rating in the current recommendations of the U.S. Preventative Services Task Force (USPSTF);
- immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

- preventive care and screenings for infants, children, and adolescents as outlined in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- preventive care and screenings for women as outlined in the comprehensive guidelines as supported by HRSA.

Covered early detection services, *preventive care services* (for example, pediatric preventive office visits), and adult and pediatric immunizations/vaccination are based on the most currently available guidelines and are subject to change.

The amount you pay for early detection services, preventive *care services*, and adult and pediatric immunizations/vaccination is indicated in the Summary of Medical Benefits.

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

Nutritional Counseling
Nutritional counseling is covered. It must be prescribed by a physician and performed by a registered dietitian/nutritionist. Nutritional counseling visits may be covered for healthy individuals seeking nutritional information, desiring weight loss, or for the purpose of treating an illness.

Smoking Cessation Programs
In accordance with Rhode Island General Law §27-20-53, this *agreement* provides coverage for smoking cessation *programs*. Smoking cessation *programs* include, but are not limited to, the following:

- Smoking cessation counseling, such counseling must be provided by a physician or upon his or her referral by a qualified licensed practitioner.
- Over-the-counter or FDA approved nicotine replacement therapy and/or smoking cessation prescription drugs when medically necessary, prescribed by a physician, and purchased at a pharmacy. See Summary of Pharmacy Benefits for details on coverage.

  Related Exclusions
  This *agreement* does not provide coverage for:
  - nicotine replacement therapy without a prescription;
  - nicotine replacement therapy when bought from a *provider* other than a pharmacy; and
  - nicotine replacement therapy and smoking cessation prescription drugs when bought from a mail order pharmacy.

Vaccinations/Immunizations
Adult Vaccinations/Immunizations
We cover adult preventive vaccinations and immunizations in accordance with current guidelines. These guidelines are subject to change. Our *allowance* includes the administration and the vaccine.

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

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

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

Pediatric Preventive Immunizations
Pediatric preventive immunizations for a *subscriber* are covered in accordance with current guidelines. The guidelines are subject to change.

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

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

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

Preventive Screening/Early Detection Services
Preventive screening such as pap smears and mammograms are covered based on the guidelines noted above. Coverage levels are as specified in the Summary of Medical Benefit

One pap smear annually is covered at the level of coverage for early detection services as shown in the Summary of Medical Benefits. The level of coverage for your second and subsequent pap smear is covered as a lab test. For information about lab, radiology, and machine tests see Section 3.34 – Tests, Imaging, and Labs.

3.29 Radiation Therapy/Chemotherapy Services

Medically necessary high dose chemotherapy and radiation services related to autologous bone marrow transplantation is limited. See definition of *Experimental/Investigational* – Section 8.0.

Inpatient
Radiation therapy and chemotherapy services are covered as a *hospital service*. See Section 8.0 – definition of *hospital services.*

Outpatient/ In a Doctor's Office
Radiation Therapy
We cover *hospital* and *doctor* services for outpatient radiation therapy. Radiation physics, dosimetry services, treatment devices, and *hospital services* are included in radiation treatment planning and therapy and are covered as part of our *allowance* for radiation therapy.

Chemotherapy Services
This *agreement* covers the *doctor's* administration fee and associated *hospital* supplies. For information about anti-neoplastic (chemotherapy) prescription drug coverage, see Section 3.27 - Prescription Drugs.

In Your Home
Radiation Therapy
This *agreement* does NOT cover radiation treatment services received in your home.

Chemotherapy Services
This *agreement* covers the *doctor's* administration fee. For information about anti-neoplastic (chemotherapy) prescription drug coverage, see Section 3.27 - Prescription Drugs.

3.30 Respiratory Therapy

Inpatient
We cover *inpatient* respiratory therapy services as a *hospital service*. See Section 8.0 - definition of *hospital services*.

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

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

In Your Home
We cover durable medical equipment and oxygen at the same *benefit limit* and level of coverage as stated in the Summary of Medical Benefits for medical equipment and medical supplies. See Section 3.8 – Durable Medical Equipment, Medical Supplies, and Prosthetic Devices for details.

Related Exclusions
This *agreement* does NOT cover respiratory therapy services when received in your home, unless received through a home care *program* or hospice care *program*. See Section 3.14 - Home Health Care and Section 3.15 – Hospice Care.

3.31 Skilled Care in a Nursing Facility

Care in a skilled nursing facility is covered if:

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

Related Exclusions
This *agreement* does NOT cover custodial care, respite care, day care, or care in a facility that is not approved by us. See Section 4.5 - Services Provided by Facilities We Have Not Approved.

3.32 Speech Therapy

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

Inpatient
We cover *inpatient hospital* and skilled nursing facility speech therapy as a *hospital service*. See Section 8.0 - definition of *hospital services*.

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

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

Speech therapy services must relate to:
- performing basic functional communication; or
- assessing or treating (or both) swallowing dysfunction.

See the Summary of Medical Benefits for *benefit limits* and your *copayment* amount.

Some services rendered by a speech therapist are classified as diagnostic tests. See Section 3.34. and the Summary of Medical Benefits for *benefit limits* and level of coverage.

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

Related Exclusions
This *agreement* does NOT cover these services if another entity or agency which provides services for the health of school children or children with disabilities is responsible for such services under state or federal laws. (See generally, Title 16, Chapters 21, 24, 25 and 26 of the Rhode Island General Laws. See also applicable regulations about health of school children and the special education of children with disabilities or similar rules set forth by federal law.)

This *agreement* does not cover:
- *maintenance services;*
- educational classes and services for impairments that are self-correcting; or
- services related to food aversion or texture disorders.

This *agreement* does not cover language and communication *developmental services* including, but not limited to, the following:
- psychosocial speech delay;
- expressive language delay;
- behavioral problems;
- attention disorders;
- conceptual handicap;
- mental retardation;

- autism;
- developmental delay; or
- stammering and stuttering.

3.33 Surgery Services

General Surgery

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

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

Multiple Surgeries

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

If More Than One Surgeon Operates

In addition to the type and purpose of surgery, our *allowance* differs depending on the number of surgeons involved, including assistant surgeons.

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

Related Exclusions

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

Mastectomy Services

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

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

related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

Surgery to Treat Functional Deformity or Impairment

Reconstructive surgery and procedures are covered under this *agreement* when performed to correct:

- a functional deformity due to a previous therapeutic process; or
- a documented functional impairment caused by trauma, congenital anomaly or disease.

Functional indications for surgical correction do not include psychological, psychiatric or emotional reasons.

We cover some surgical procedures to treat functional impairments. We cover those procedures listed below to treat functional impairments when *medically necessary:*

- Abdominal wall surgery including Panniculectomy (other than an abdominoplasty);
- Blepharoplasty and Ptosis Repair;
- Gastric Bypass or Gastric Banding;
- Nasal Reconstruction and Septorhinoplasty;
- Orthognathic surgery including Mandibular and Maxillary Osteotomy;
- Reduction Mammoplasty;
- Removal of Breast Implants;
- Removal or Treatment of Proliferative Vascular Lesions and Hemangiomas; or
- Treatment of Varicose Veins.

We may need to review the following medical documentation to be able to make a decision about coverage for the above listed procedures:

- history and physical;
- preoperative diagnostic studies;
- previously tried conservative medical therapy and photographs; or
- other medical records.

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

Related Exclusions

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

This *agreement* does NOT cover orthodontic services related to orthognathic surgery.

This *agreement* does NOT cover cosmetic procedures. Cosmetic procedures are performed primarily:

- to refine or reshape body structures that are not functionally impaired;
- to improve appearance or self-esteem; or
- for other psychological, psychiatric or emotional reasons.

Drugs, biological products, *hospital charges*, pathology, radiology fees and *charges* for surgeons, assistant surgeons, attending physicians and any other incidental services which are related to cosmetic surgery are NOT covered. *Medically necessary* surgery performed at the same time as a cosmetic procedure is also NOT covered.

The following procedures are NOT covered under this *agreement*:

- Abdominoplasty;
- Cervicoplasty;
- Chemical exfoliations, peels, abrasions (or dermabrasions or planing for acne, scarring, wrinkling, sun damage or other benign conditions);
- Correction of variations in normal anatomy including augmentation mammoplasty, mastopexy, and correction of congenital breast asymmetry;
- Dermabrasion;
- Ear Piercing or repair of a torn earlobe;
- Excision of Excess Skin or Subcutaneous Tissue (except Panniculectomy as listed above);
- Genioplasty;
- Gynecomastia surgery, including but not limited to mastectomy and reduction mammoplasty;
- Hair Transplants;
- Hair Removal (including electrolysis epilation);
- Inverted nipple surgery;
- Laser treatment for acne, and acne scars, and vitiligo;
- Osteoplasty- Facial Bone Reduction;
- Otoplasty;
- Procedures to correct visual acuity including, but not limited to, cornea surgery or lens implants;
- Removal of Asymptomatic Benign Skin Lesions;
- Repeated cauterizations or electrofulguration methods used to remove growths on the skin;

- Rhinoplasty;
- Rhytidectomy;
- Scar Revision, regardless of symptoms;
- Sclerotherapy for Spider Veins;
- Subcutaneous Injection of Filling Material;
- Suction assisted Lipectomy;
- Tattooing or Tattoo Removal (except tattooing of the nipple/areola related to a mastectomy); or
- Testicular prosthesis surgery.

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

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

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

Other than the pre-operative office visit, this *agreement* covers office visits or office consultations to anesthesiologists as an office visit. See Section 3.23 - Office Visits.

Anesthesia services when rendered at a *hospital* or *free-standing ambulatory surgi-center* in connection with a dental service are covered when the use of the *hospital* or *free-standing ambulatory surgi-center* is *medically necessary* and the setting in which the service received is determined to be appropriate. *Preauthorization* is recommended for this service. The dental services will remain non-covered. See Section 4.17.

Related Exclusions
This *agreement* does NOT cover:
- local anesthesia provided by an anesthesiologist or anesthesia administered by a surgeon, assistant surgeon, or obstetrician;
- services of a standby anesthesiologist; and

- patient controlled analgesia, also known as pain management.

3.34 Tests, Imaging and Labs (Includes Machine tests and X-rays)

Inpatient/Outpatient/In a Doctor's Office

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

- Laboratory tests including blood tests, urinalysis, pap smears, and throat cultures. Some lab tests are not covered. See the Related Exclusions in this section.
- Machine tests including Electrocardiograms (EKGs), Electroencephalograms (EEGs), and nerve conduction tests.
- Imaging including plain film radiographs (x-rays);
- Ultrasonography (ultrasounds);
- Mammograms;
- Magnetic Resonance Imaging (MRI);
- Magnetic Resonance Angiography (MRA);
- Computerized Axial Tomography (CAT or CT scans);
- Nuclear scans; and
- Positron Emission Tomography (PET scan).

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

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

- MRI;
- MRA;
- CAT scans;
- CTA scans;
- PET scans; and
- Nuclear Cardiac Imaging.

Our *allowance* includes one reading or interpretation of a diagnostic imaging, lab, or machine test.

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

If a diagnostic imaging, lab or machine test service is rendered and a surgical procedure is performed at the same time, the amount that you pay for each service is based on the type of service being rendered. For surgical services (including but not limited to biopsies, lesion removals, or endoscopies) see Section 3.33 Surgery Services. For diagnostic imaging, labs, or machine tests see Section 3.34 – Tests, Imaging, and Labs.

For *Preventive Care Services* and Early Detection Services, see Section 3.28.

If a diagnostic imaging, lab or machine test service is rendered and a surgical procedure is performed at the same time, the amount that you pay for each service is based on the type of service being rendered. For surgical services (including but not limited to biopsies, lesion removals, or endoscopies) see Section 3.33 Surgery Services. For diagnostic imaging, labs, or machine tests see Section 3.34 – Tests, Imaging, and Labs.

Related Exclusions

This *agreement* does NOT cover the following:

- re-reading of diagnostic tests by a second *doctor;*
- dental X-rays (except when ordered by a *doctor*/dentist to diagnose a condition due to an accident to your *sound natural teeth*. See Section 3.16 – Hospital Emergency Room Services for details);
- bone marrow blood supply MRI;
- genetic testing for screening purposes;
- audiometric hearing or speech services if another entity or agency is responsible for such services under state or federal laws which provide service for the health of school children or children with disabilities. (See generally, Title 16, Chapters 21, 24, 25, and 26 of the Rhode Island General Laws. See also regulations about the health of school children and the special education of children with disabilities or similar rules set forth by federal law or state law of applicable jurisdiction.);
- over the counter diagnostic devices or kits even if prescribed by a physician, except for those devices or kits related to the treatment of diabetes; or
- home sleep studies, unless administered and attended by a sleep technologist;
- nicotine lab tests.

Lyme Disease Diagnosis and Treatment

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

For coverage of specific services, 3.23 - Office Visits, 3.19- Infusion Therapy, and for prescription drugs, Section 3.27 and Pharmacy Benefits.

3.35 Urgent Care

We cover *medically necessary* visits to an *urgent care center*. These centers are also referred to as "walk-in centers".

3.36 Vision Care Services

Eye Examinations

We cover one (1) routine eye examination per *calendar year* if an optometrist or ophthalmologist performs the examination. *Medically necessary* eye examinations are covered.

4.0 HEALTH CARE SERVICES NOT COVERED UNDER THIS AGREEMENT

This *agreement* does NOT cover health care services which:

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

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

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

This *agreement* only covers services listed under Section 3.0 - *Covered Health Care Services.* If a service or category of service is not listed as covered, it is not covered under this *agreement.* This *agreement* does NOT cover services that may otherwise be considered covered when provided with a non-covered course of service or as part of a non-covered regimen of care.

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

4.1 Services Not Medically Necessary

This *agreement* does NOT cover *hospital* care (admission tests, services, supplies, or continued care), medical care, rehabilitation, or any other treatment, procedure, facility, equipment, drug, device, supply or service which is NOT *medically necessary*.

We will use any reasonable means to make a determination about the medical necessity of this care. We may look at *hospital* records, reports and *hospital utilization review* committee statements. We review medical necessity in accordance with our medical policies and related guidelines. You have the right to appeal our determination or to take legal action as described in Section 7.0.

We may deny payments if a *doctor* or *hospital* does not supply medical records needed to determine medical necessity. We may also deny or reduce payment if the records sent to us do not provide adequate justification for performing the service.

This *agreement* does NOT cover routine screenings or tests performed by a *hospital* which are not *medically necessary* for the diagnosis or treatment of your condition. This *agreement* does NOT cover routine screenings or tests which are not specifically ordered by the *doctor* who admits you.

4.2 Government Covered Services

This *agreement* does NOT cover medical expenses for any condition, illness, or disease which should be covered by the United States government or any of its agencies, Medicare, any state or municipal government or any of its agencies (except *emergency* care when there is a legal responsibility to provide it). This *agreement* does NOT cover services for military-related conditions. This *agreement* does not cover services or supplies required as a result of war, declared or undeclared, or any military action which takes place after your coverage becomes effective.

4.3 Other States Mandated Laws

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

4.3 Behavioral Training Assessment

This *agreement* does not cover behavioral training assessment, education or exercises including applied behavioral analysis.

4.4 College/School Health Facilities Services

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

4.5 Facilities We Have Not Approved

This *agreement* does NOT cover custodial care, rest care, day care, or non-skilled care in any facility. This *agreement* does NOT cover care in convalescent homes, nursing homes, homes for the aged, halfway houses, or other residential facilities. This *agreement* does NOT cover *hospital services* which are not performed in a *hospital.* See Section 8.0 - Glossary.

4.6 Excluded Providers

This *agreement* does NOT cover health care services performed by a *provider* who has been excluded or debarred from participation in Federal programs, such as Medicare and Medicaid. To determine whether a *provider* has been excluded from a Federal program, visit the U.S. Department of Human Services Office of Inspector General website (www.oig.hhs.gov/fraud/exclusions/listofexcluded.html) or the Excluded Parties List System website maintained by the U.S. General Services Administration (www.epls.gov).

4.7 People/Facilities Who Are Not Legally Qualified or Licensed

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

4.8 Naturopaths and Homeopaths

This *agreement* does NOT cover health care services ordered or performed by naturopaths and homeopaths.

4.9 If You Leave the Hospital or If You Are Discharged Late

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

4.10 Benefits Available from Other Sources

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

This *agreement* does NOT cover health care services if another entity or agency is responsible for such services under state or federal laws which provide service for the health of school children or children with disabilities. (See generally, Title 16, Chapters 21, 24, 25, and 26 of the Rhode Island General Laws. See also applicable regulations about the health of school children and the special education of children with disabilities or similar rules set forth by federal law or state law of applicable jurisdiction.)

4.11 Blood Services

This *agreement* does NOT cover penalty fees related to blood services. This *agreement* does NOT cover any services for drawing, processing, or storage of your own blood.

4.12 Charges for Administrative Services

This *agreement* does NOT cover:

- *charges* for missed appointments;
- *charges* for completion of *claim* forms; or
- other administrative *charges.*

4.13 Christian Scientist Practitioners

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

4.14 Clerical Errors

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

4.15 Consultations -Telephone

This *agreement* does NOT cover telephone consultations, telephone services or medication monitoring services by phone. This includes, but is not limited to, services provided by a behavioral health (mental health and *chemical dependency*) *provider* covered under this *agreement*.

4.16 Deductibles and Copayments

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

4.17 Dental Services

This *agreement* does NOT cover:

- general dental services (such as extractions, including full mouth extractions, prostheses, braces, operative restorations, fillings, medical or surgical treatment of dental caries, gingivitis, gingivectomy, impactions, periodontal surgery, non-surgical treatment of temporomandibular joint dysfunctions, including appliances or restorations necessary to increase vertical dimensions or to restore the occlusion) except for one (1) cleaning per *calendar year*. See Section 3.6 – Dental Services.;
- dental x-rays (except for one (1) set of bitewings per *calendar year*. See 3.6 –Dental Services.)
- panorex X-rays (except when ordered by a *doctor* or dentist to diagnose a condition due to an accident to your *sound natural teeth* (see Section 3.11-Emergency Services for details) ;
- orthodontic services, even if related to a covered surgery;
- dental appliances or devices; and
- *hospital services*, *free-standing ambulatory surgi-center* services, and anesthesia services provided in connection with a dental service when the use of the *hospital* or *free-standing ambulatory surgi-center* or the setting in which the services are received is not *medically necessary*.

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

- apicoectomy, per tooth, first root;
- alveolectomy including curettage of osteitis or sequestrectomy;
- alveoloplasty, each quadrant ;
- complete surgical removal of inaccessible impacted mandibular tooth mesial surface;
- excision of feberous tuberosities;
- excision of hyperplastic alveolar mucosa, each quadrant;

- operculectomy excision periocoronal tissues;
- removal of partially bony impacted tooth;
- removal of completely bony impacted tooth, with or without unusual surgical complications;
- surgical removal of partial bony impaction;
- surgical removal of impacted maxillary tooth;
- surgical removal of residual tooth roots; or
- vestibuloplasty with skin/mucosal graft and lowering the floor of the mouth.

4.18 Employment–Related Injuries

This *agreement* does NOT cover health care services when performed to treat work-related illnesses, conditions, or injuries whether or not you are covered by Workers' Compensation law, unless;

- you are self-employed, a sole stockholder of a corporation, or a member of a partnership;
- such work-related illnesses, conditions, or injuries were incurred in the course of your self-employment, sole stockholder, or partnership activities; AND
- you are not enrolled as an employee under a group health *plan* sponsored by an employer other than the business or partnership described above.

4.19 Eye Exercises

Eye exercises and visual training services are NOT covered.

4.20 Eyeglasses and Contact Lenses

Eyeglasses and contact lenses are NOT covered, unless specifically listed as a *covered health care service* in Section 3 – Covered Health Care Services of this *agreement.*

4.21 Food and Food Products

This *agreement* does NOT cover food or food products, whether or not prescribed, unless required by Rhode Island General Law §27-20-56 (Enteral Nutrition Products), or delivered through a feeding tube as the sole source of nutrition.

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

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

4.23 Gene Therapy, Genetic Screening, and Parentage Testing

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

4.24 Illegal Drugs and Chronic Addiction

Drugs which are dispensed in violation of state or federal law are NOT covered. Methadone dispensed to treat *chemical dependency* is NOT covered.

4.25 Infant Formula

This *agreement* does NOT cover infant formula whether or not prescribed unless required by Rhode Island General Law §27-20-56 (Enteral Nutrition Products) or delivered through a feeding tube as the sole source of nutrition.

4.26 Marital Counseling

This *agreement* does NOT cover marital counseling or training services.

4.27 Personal Appearance and/or Service Items

Services and supplies for your personal appearance and comfort, whether or not prescribed by a *doctor* and regardless of your condition, are NOT covered. These services and supplies include, but are not limited to:

- radio,
- telephone,
- television,
- air conditioner,
- humidifier,
- air purifier, or
- beauty and barber services.

Travel expenses, whether or not prescribed by a *doctor*, are NOT covered. This *agreement* does NOT cover items whose typical function is not medical. These items include, but are not limited to, recliner lifts, air conditioners, humidifiers, or dehumidifiers.

This *agreement* does NOT cover items that do not meet the durable medical equipment, medical supplies, and prosthetic devices minimum specifications. These items include, but are not limited to:

- standers,
- raised toilet seats,
- toilet seat systems ,
- cribs,
- ramps,
- positioning wedges,
- wall or ceiling mounted lift systems,
- water circulating cold pads (cryo-cuffs) ,

- car seats (including any vest system) or car beds,
- bath or shower chair systems,
- trampolines,
- tricycles,
- therapy balls, or
- net swings with a positioning seat.

4.28 Private Duty Nursing Service

This *agreement* does NOT cover private duty nursing services.

4.29 Psychoanalysis for Educational Purposes

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

4.30 Research Studies

This *agreement* does NOT cover research studies.

4.31 Reversal of Voluntary Sterilization

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

4.32 Services Provided By Relatives or Members of Your Household

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

4.33 Sex Transformations and Dysfunctions

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

4.34 Supervision of Maintenance Therapy

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

4.35 Surrogate Parenting

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

4.36 Therapies, Acupuncture and Acupuncturist Services, and Biofeedback

This *agreement* does NOT cover:

- recreational therapy,
- aqua therapy,
- maintenance therapy,
- aromatherapy
- massage therapy rendered by a massage therapist, and
- therapies, procedures, and services for the purpose of relieving stress are NOT covered.

This *agreement* does NOT cover acupuncture and acupuncturist services, including X-ray and laboratory services ordered by an acupuncturist.

This *agreement* does NOT cover:

- pelvic floor electrical stimulation,
- pelvic floor magnetic stimulation,
- pelvic floor exercise,
- biofeedback training,
- biofeedback by any modality for any condition, and
- any other exercise therapy.

4.37 Weight Loss Programs

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

5.0 HOW YOUR COVERED HEALTH CARE SERVICES ARE PAID

This *agreement* uses Preferred Blue which is the *BlueCard* PPO network. With a Preferred Provider Organization (PPO), *network providers* enter into a contract with us or an out of state Blue Cross and Blue Shield plan and agree to provide *covered health care services* to our *members*. *Network providers* accept our *allowance* as payment in full, less any *copayment* or *deductible*.

Payments made to Rhode Island *providers* are based on our *allowance*. Payments made to providers located in other states are based on the *BlueCard* programs. *Network* and *non-network provider* payment information is explained in Section 5.1, 5.2, and 5.3 below.

5.1 How Network Providers Are Paid

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

It is your obligation to pay a *network provider* your *copayment, deductible,* and the difference between the *maximum benefit* and our *allowance*. If you do not pay the *network provider*, the *provider* may decline to provide current or future services to you. The *provider* may pursue payment from you. See Section 1.9 – Your Responsibility to Pay Your Providers for more information.

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

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

5.2 How Non-Network Providers Are Paid

You are responsible for paying all *charges* from a *non-network provider.* You are liable for the difference between the amount that the *non-network* health care *provider* bills and the payment we make for covered health care services. Generally, we send reimbursement to you; but, we do reserve the right to reimburse a *non-network provider* directly.

We reimburse you or a *non-network provider* up to the *maximum benefit* or our *allowance*, less any *copayments* and *deductibles* which may apply to a *covered health care service.* We reimburse non-*network provider* services using the same guidelines we use to pay *network providers*.

Generally, our payment for *non-network provider* services will not be more than the amount we pay for *network provider* services. Payments we make to you are personal. You cannot transfer or assign any of your right to receive payments under this *agreement* to another person or organization, unless the Rhode Island General Law §27-20-49 (Dental Insurance assignment of benefits) applies.

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

Out-of-Area Services

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs". Whenever you obtain health care services outside of our service area, the *claims* for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside our service area, you will obtain care from health care *providers* that have a contractual agreement (i.e., are *network providers*) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from *non- network* health care *providers*. Our payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access covered health care services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care *providers*.

Whenever you access covered health care services outside our service area and the *claim* is processed through the BlueCard Program, the amount you pay for covered health care services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care *provider*. Sometimes, it is an estimated price that takes into account special arrangements with your health care *provider* or *provider* group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may

be an average price, based on a discount that results in expected average savings for similar types of health care *providers* after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your *claim* because they will not be applied retroactively to *claims* already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered health care services according to applicable law.

Non-Network Healthcare Providers Outside Our Service Area

Subscriber Liability Calculation
When covered health care services are provided outside of our service area by *non-network* health care *providers*, the amount you pay for such services will generally be based on either the Host Blue's *non-network* health care *provider* local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the *non-network* health care *provider* bills and the payment we will make for the covered services as set forth in this paragraph.

Exceptions
In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the health care services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by *non-network* health care *providers*. In these situations, you may be liable for the difference between the amount that the *non-network* health care *provider* bills and the payment we will make for the covered services as set forth in this paragraph.

6.0 HOW WE COORDINATE YOUR BENEFITS WHEN YOU ARE COVERED BY MORE THAN ONE PLAN

Introduction

This Coordination of Benefits ("COB") provision applies when you or your covered dependents have health care benefits under more than one *plan*.

We follow the COB rules of payment issued by the National Association of Insurance Commissioners (NAIC). The COB rules have been adopted by the Rhode Island Office of the Health Insurance Commissioner (OHIC). From time to time these rules may change before we issue a revised subscriber agreement. We use the COB regulations in effect at the time of coordination to determine benefits available to you under this *agreement*.

If this provision applies, the order of benefit determination rules as stated in this section will determine whether we pay benefits before or after the *benefits* of another *plan*.

6.1 Definitions

The following definitions apply to Section 6:

ALLOWABLE EXPENSE means the necessary, reasonable and customary item of expense for health care which is:

- covered at least in part under one or more *plans* covering the person for whom the *claim* is made; AND
- incurred while this *agreement* is in force.

When a *plan* provides health care benefits in the form of services, the reasonable cash value of each service is considered as both an *allowable expense* and a benefit paid.

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

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

PLAN means any health care insurance benefit package provided by an organization as defined in Section 8.0 - Glossary.

PRIMARY PLAN means a *plan* whose benefits for a person's health care coverage must be determined without taking the existence of any other *plan* into consideration.

SECONDARY PLAN means a *plan* which is not a *primary plan*.

6.2 When You Have More Than One Agreement with Blue Cross & Blue Shield of Rhode Island

If you are covered under more than one *agreement* with us, you are entitled to covered *benefits* under both *agreements*. If one *agreement* has a *benefit* that the other(s) does not, you are entitled to coverage under the *agreement* that has the benefit. The total payments you receive will never be more than the total cost for the services you receive.

6.3 When You Are Covered By More Than One Insurer

Covered benefits provided under any other *plan* will always be paid before the *benefits* under our *plan* if that insurer does not use a similar coordination of benefits rule to determine coverage. The *plan* without the coordination of benefits provision will always be the *primary plan*.

Benefits under another *plan* include all *benefits* that would be paid if *claims* had been submitted for them.

If you are covered by more than one *plan* and both insurers use similar coordination of benefits rules to determine coverage, we use the following conditions to determine which *plan* covers you first:

- whether you are the main *subscriber* or a dependent;
- if married, whether you or your spouse was born earlier in the year; OR
- length of time each spouse has been covered.

(1.) Non-Dependent/Dependent - If you are covered under a *plan* and you are the main *subscriber*, the *benefits* of that *plan* will be determined before the *benefits* of a *plan* which covers you as a dependent.

If, however, you are a Medicare beneficiary, Medicare will be the *primary plan*. Medicare will provide the *benefits* first.

If one of your dependents covered under this *agreement* is a student, the *benefits* of any other coverage available because of student enrollment (except accident-only type coverage) will be determined before the *benefits* under this *agreement.*

(2.) Dependent Child/Parents Not Separated or Divorced - If dependent children are covered under separate *plans* of more than one person (i.e. "parents" or individuals acting as "parents"), the *benefits* of the *plan* covering the parent born earlier in the year will be determined before those of the parent whose birthday falls later in the year. If both parents have the same birthday, the *benefits* of the *plan* which covered the parent longer are determined before those of the *plan* which covered the other parent for a shorter period of time. The term "birthday" only refers to the month and day in a *calendar year*, not the year in which the person was born. If the other *plan* does not determine *benefits* according to the parents' birth dates, but by parents' gender instead, the other *plan's* gender rule will determine the order of *benefits*.

(3.) Dependent Child/Parents Separated or Divorced - If two or more *plans* cover a person as a dependent child of divorced or separated parents, the *plan* responsible to cover *benefits* for the child will be determined in the following order:

- first, the *plan* of the parent with custody of the child;
- then, the *plan* of the spouse of the parent with custody of the child; AND
- finally, the *plan* of the parent not having custody of the child.

If the terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the parent's *benefits* under that parent's *plan* has actual knowledge of those terms, the *benefits* of that *plan* are determined first and the *benefits* of the *plan* of the other parent are the *secondary plan*.

If the terms of a court decree state that the parents share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the *plans* covering the child will follow the order of benefit determination rules outlined in Section 6.3 (2) above.

(4.) Active/Inactive Employee - If you are covered under another health *plan* as an employee (not laid off or retired), your *benefits* and those of your dependents under that *plan* will be determined before benefits under this *plan*.

(5.) Longer/Shorter Length of Coverage - If none of the above rules determine the order of *benefits*, the *benefits* of the *plan* which covered a *member* or *subscriber* longer are determined before those of the *plan* which covered that person for the shorter term.

In general, if you use more *benefits* than you are covered for during a benefit period, the following formula is used to determine coverage:
The insurer covering you first will cover you up to its allowance. Then, the other insurer will cover any allowable *benefits* you use over that amount. It will never be more than the total amount of coverage that would have been provided if *benefits* were not coordinated.

Maximum *benefits* paid by first insurer
\+ Any remaining *allowable expense* paid by other insurer

Total Benefits Payable

6.4 Our Right to Make Payments and Recover Overpayments

If payments which should have been made by us according to this provision have actually been made by another organization, we have the right to pay those organizations the amounts we decide are necessary to satisfy the rules of this provision. These amounts are considered *benefits* provided under this *agreement* and we are not liable for them.

If we have made payments for *allowable expenses* which are more than the maximum amount needed to satisfy the conditions of this provision, we have the right to recover the excess amounts from: the person to or for whom the payments were made; any other insurers; and/or any other organizations (as we decide). As the *subscriber*, you agree to pay back any excess amount, provide information and assistance, or do whatever is necessary to recover this excess amount. When determining the amount of payments made we include the reasonable cash value of any *benefits* provided in the form of services.

7.0 HOW TO FILE AND APPEAL A CLAIM

Our Customer Service Department phone number is (401) 459-5000 or 1-800-639-2227.

7.1 How to File a Claim

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

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

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

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

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

- patient's name;
- your *member* identification number;
- the name, address, and telephone number of the *provider* who performed the service;
- date and description of the service; AND
- *charge* for that service.

Please mail the *claim* to:

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

7.2 Complaint and Administrative Appeal Procedures

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

An **Administrative Appeal** is a verbal or written request for us to reconsider a full or partial denial of payment for services that were denied because:

- the services were excluded from coverage;
- we failed to make payment (in whole or part) for a service;
- we determined that you were not initially eligible for coverage ;

- we determined that you were not eligible for coverage (for example, a *rescission* of coverage occurred);
- you or you or your *provider* did not follow Blue Cross & Blue Shield of Rhode Island's requirements; or
- other limitation on an otherwise covered benefit.

How to File a Complaint or Administrative Appeal

If you are dissatisfied with any aspect of our operation, the quality of care you have received, or you have a request for us to reconsider a full or partial denial of benefits, please call our Customer Service Department. The Customer Service Representative will try to resolve your concern. If it concern is not resolved to your satisfaction, you may file a *complaint* or *administrative appeal* verbally with the Customer Service Representative. If you wish to file a *complaint* related to the quality of care you received, you must do so within sixty (60) days of the incident. If you wish to file an *administrative appeal*, you must do so within one hundred eighty (180) days of receiving a denial of benefits. You are not required to file a *complaint* before filing an *administrative appeal*.

You may also file a *complaint* or *administrative appeal* in writing. To do so, you must provide the following information:

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

You can use the Member Appeal Form, which a Customer Service Representative can provide to you, or you can send us a letter with the information requested above. If someone is filing a *complaint* or *administrative appeal* on your behalf, you must send us a notice with your signature, authorizing the individual to represent you in this matter.

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

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

We will acknowledge your *complaint* or *administrative appeal* in writing or by phone within ten (10) business days of our receipt of your written *complaint* or *administrative appeal.* The Grievance and Appeals Unit will conduct a thorough review of your *complaint* or *administrative appeal* and respond in the timeframes set forth below.

Complaint

- **Level 1**
  We will respond to your Level 1 *complaint* in writing within thirty (30) calendar days of the date we receive your *complaint*. The determination letter will provide you with the rationale for our response as well as information on the next steps available to you, if any, if you are not satisfied with the outcome of the *complaint*.

- **Level 2 (when applicable)**
  A Level 2 *complaint* may be submitted only when you have been offered a second level of *complaint* in your Level 1 determination letter. The Grievance and Appeals Unit will conduct a thorough review of your Level 2 *complaint* and respond to you in writing within thirty (30) business days of the date we receive your Level 2 letter. Our determination letter will provide you with the rationale for our response as well as information on the next steps if you are not satisfied with the outcome of the *complaint*.

Administrative Appeal

We will respond to your a*dministrative appeal* in writing within sixty (60) calendar days of our receipt of your *administrative appeal*. The determination letter will provide you with information regarding our determination.

Blue Cross & Blue Shield of Rhode Island does not offer a Level 2 *administrative appeal*. You may notify the State of Rhode Island Department of Health or the State of Rhode Island Office of the Health Insurance Commissioner about your concerns. Please refer to the Legal Action section below for more information.

7.3 Medical Appeal Procedures

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

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

If we deny payment for a service for medical reasons, you will receive the denial in writing. The written denial you receive will explain the reason for the denial and provide specific instructions for filing a *medical appeal*.

To file a *medical appeal* verbally, you may call our Customer Service Department.

You may also file a *medical appeal* in writing by providing the following information:

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

If someone is filing a *medical appeal* on your behalf, you must send us a notice with your signature, authorizing the individual to represent you in this matter.

Written *medical appeals* should be sent to:

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

Your *doctor* may also file a *medical appeal* on your behalf. Your *doctor* can contact the Physician and Provider Service Center to start the medical appeal.

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 phone acknowledge of our receipt of the *medical appeal*.

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

Appeal level

You may file a *medical appeal* by making a request for such review to us within one hundred and eighty (180) calendar days of the initial determination letter. You may do so by calling our Customer Service Department, but we strongly suggest that you submit your request in writing to ensure your request is accurately reflected. At any time during the appeal, you may supply

additional information by mailing it to the address listed above. You may request copies of information relevant to your appeal (free of charge) by contacting our Grievance and Appeal Unit.

For pre-service (before services are rendered) or concurrent (during a patient's hospital stay or course of treatment) appeals, you will receive written notification of the determination within fifteen (15) calendar days of receipt of the appeal. If you are requesting reconsideration of a service that was denied after you already obtained the service (retrospectively), then you will receive written notification of our determination within fifteen (15) business days of our receipt of the appeal.

Expedited (Urgent) Review
You may ask for an expedited (urgent) appeal if:

- an urgent *preauthorization* request for health care services has been denied (See Section 1.6 – Preauthorization for additional information about urgent *preauthorization* requests);
- the circumstances are an emergency; or
- you are in an *inpatient* setting.

A review is considered emergent or urgent if, in the opinion of an individual applying the judgment of a prudent layperson possessing an average knowledge of health and medicine, applying time periods for making a non-urgent appeal determination could seriously jeopardize your life or your health or your ability to regain maximum function. Likewise, a review is considered emergent or urgent if, in the opinion of a physician with knowledge of your health condition, applying time periods for making a non-urgent claim determination would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal

To request you or your physician or provider must call the Grievance and Appeals Unit at (401) 459-5000 or 1-800-639-2227 or fax your request to (401) 459-5005.

An expedited appeal determination for services that have not yet been rendered (a pre-service review) will be made not later than seventy-two (72) hours from the receipt of the request.

Services that have all ready been rendered (retrospective review) are not eligible for expedited (urgent) review.

External Appeal
If you remain dissatisfied with our appeal determination, you may request an external review by an outside review agency. To request an external review you must submit your request in writing to us within four (4) months of your receipt of the determination We will forward your request to the outside review agency within five (5) business days, or two (2) business days for an expedited external appeal.

For all non-emergency appeals, the outside review agency will notify you of its determination within ten (10) business days of the agency's receipt of the information.

For all urgent external appeals, the outside review agency will notify you of its determination within two (2) business days.

This External Appeal is voluntary. This means you may choose to participate in this level of appeal, or you may file suit in an appropriate court of law (Please see Legal Action, below).

7.4 Legal Action

If you are dissatisfied with the decision on 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.

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

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 (see Section 6.1).

7.5 Grievances Unrelated to Claims

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

You may also access our *complaint* and grievance procedures if you have a *complaint* about our service or about one of our employees. In order to start a grievance, please call our Customer Service Department. The Customer Service Department will log in your call and begin working towards the resolution of your *complaint*.

The grievance procedures described in this Section 7.4 do not apply to medical necessity determinations (see Section 7.3), *complaints* about payments (see Section 7.2), *claims* of medical malpractice or to allegations that we are liable for the professional negligence of any *doctor*, *hospital*, health care facility or other health care *provider* furnishing services under this *agreement.*

7.6 Our Right to Withhold Payments

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

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

7.7 Our Right of Subrogation and/or Reimbursement

Definitions

SUBROGATION means we can use your right to recover money from a third party who caused you to be hurt or sick. We may also recover from any insurance company (including uninsured and underinsured motorist clauses and no-fault insurance) or other party.

REIMBURSEMENT means our right to be paid back any payments, awards or settlements that you receive from a third party. We can collect up to the amount of any benefit or any payment we made.

Subrogation

We may recover money from a third party that causes you to be hurt or sick. If that party has insurance, we may recover money from the insurance company. Our recovery will be based on the *benefit* or payment we made under this *agreement.* For example, if you are hurt in a car accident and we pay for your hospital stay, we can collect the amount we paid for your hospital stay from the auto insurer. If you do not try to collect money from the third party who caused you to be hurt or sick, you agree that we can. We may do so on your behalf or in your name. Our right to be paid will take priority over any claim for money by a third party. This is true even if you have a claim for punitive or compensatory damages.

Reimbursement

If we give you *benefits* or make payment for services under this *agreement* and you get money from a third party for those services, you must pay us back. This is true even if you receive the money after a settlement or a judgment. For example, if your auto insurance pays for your emergency room visit after a car accident, you must reimburse us for any *benefit* payment that we made.

We can collect the money no matter where it is or how it is designated. You must pay us back even if you do not get back the total amount of your claim against the third party. We can collect the money you receive even if it is described as a payment for

something other than health care expenses. We may offset future payments under this *agreement* until we have been paid an amount equal to what you were paid by a third party. If we must pay legal fees in order to recover money from you, we can recover these costs from you. Also, the amount that you must pay us cannot be reduced by any legal costs that you have.

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 quickly so we can respond in court.

Member Cooperation

You must give us information and help us. This means you must complete and sign all necessary documents to help us get money back. You must tell us in a timely manner about the progress of your claim with a third party. This includes filing a claim or lawsuit, beginning settlement discussions, or agreeing to a settlement in principle, etc. It also means that you must give us timely notice before you settle any claim. You must not do anything that might limit our rights under this Section. We may take any action necessary to protect our right of *subrogation* and/or *reimbursement*.

8.0 GLOSSARY

When a defined term is used in this *agreement*, it will be italicized.

AGREEMENT means this document. It is a legal contract between you and Blue Cross & Blue Shield of Rhode Island.

ALLOWANCE is the maximum amount to be acceptable for a *covered health care service*. Our *allowance* for a *covered health care service* may include payment for other related services. See Section 5.0 - How Your Covered Health Care Services Are Paid and the Summary of Benefits for services subject to *copayments, deductibles,* and *maximum benefits.*

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

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

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

BENEFIT LIMIT means the maximum benefit amount allowed for certain *covered health care services*. It may limit the dollar amount, the duration, or the number of visits for *covered health care services*. See the Summary of Benefits for details about any *benefit limits*.

BLUECARD is a national program in which all Blue Cross and Blue Shield plans participate. It benefits *subscribers* who receive *covered health care services* outside their own plan's service area. See Section 5.3 for details.

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

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

CHEMICAL DEPENDENCY means the chronic abuse of alcohol or other drugs. It is characterized:

- by impaired functioning;
- debilitating physical condition;
- the inability to keep from or reduce consuming the substance; OR

- the need for daily use of the chemical in order to function.

The term "chemical" includes alcohol and addictive drugs. It does not include caffeine or tobacco.

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

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

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

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

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

DEDUCTIBLE means the amount that you must pay each *calendar year* before we begin to pay for certain *covered health care services.* The *network provider* and *non-network provider calendar year deductibles* are added up separately. The *deductible* amount applied to a *covered health care* expense is based on the lower of our *allowance* or the *provider's charge*. See the Summary of Benefits for your *calendar year deductible* amount(s) and *benefit limits*.

DEVELOPMENTAL SERVICES means therapies, typically provided by a qualified professional using a treatment plan, that are intended to lessen deficiencies in normal age appropriate function. The therapies generally are meant to limit deficiencies related to injury or disease that have been present since birth. This is true even if the deficiency was detected during a later developmental stage. The deficiency may be the result of injury or disease during the developmental period. *Developmental services* are applied for sustained periods of time to promote acceleration in developmentally related functional capacity. This *agreement* does not cover *developmental services* unless specifically listed as covered.

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

ELIGIBLE PERSON is explained in Section 2.1. See Section 2.1 for a detailed description of who is eligible to enroll as a dependent under this *agreement.*

EMERGENCY means a medical condition manifesting itself by acute symptoms. 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.

EXPERIMENTAL/INVESTIGATIONAL means any health care service that has progressed to limited human application, but has not been recognized as proven and effective in clinical medicine. See Section 3.11 for a more detailed description of the type of health care services we consider *experimental/investigational*.

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

HOSPITAL means any facility worldwide:

- that provides medical and surgical care for patients who have acute illnesses or injuries; AND
- is either listed as a *hospital* by the American Hospital Association (AHA) OR accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

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

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

Hospital does not mean:

- convalescent homes;
- rest homes;
- nursing homes;
- homes for the aged;
- school and college infirmaries;
- halfway houses or residential facilities;

- long-term care facilities;
- *urgent care centers* or *free-standing ambulatory surgi-centers;*
- facilities providing mainly custodial, educational or rehabilitative care; or
- sections of *hospitals* used for custodial, educational or rehabilitative care, even if accredited by the JCAHO or listed in the AHA directory.

HOSPITAL SERVICES are the following in-*hospital services*:

- anesthesia supplies;
- blood services including: administration, typing, crossmatching, drawing, maintenance of donor room, and *charges* for plasma and derivatives. *Charges* for penalty fees are NOT covered;
- cardiac pacemakers;
- computerized axial tomography (CAT or CT scan) and magnetic resonance imaging (MRI);
- diagnostic imaging, radiation therapy and diagnostic and therapeutic radioisotopic services;
- drugs and medications as currently listed in the National Formulary or the U.S. Pharmacopoeia;
- electrocardiograms (EKGs) and electroencephalogram (EEG);
- general and specialty nursing care;
- hearing evaluation;
- hemodialysis - use of machine and other physical equipment;
- inhalation and oxygen, respiratory therapy, and ventilator support;
- insulin and electroconvulsive therapy;
- laboratory and pathology testing and pulmonary function tests;
- mammogram;
- meals and other dietary services;
- medical and surgical supplies;
- occupational therapy;
- original prosthetic and initial prosthesis when supplied and billed by the *hospital* where you are an *inpatient* or the *hospital* that you return to ,within a reasonable period of time, for an original prosthesis or initial prosthetic, providing the prosthesis or the prosthetic is related to the original *hospital* stay;
- pap smear;
- physical therapy;
- recovery room;
- rehabilitation services;
- room accommodations in a ward or *semi-private room*;
- services performed in intensive care units;

- services of a licensed clinical psychologist when ordered by a *doctor* and billed by a *hospital*;
- speech evaluation and therapy;
- ultrasonography (ultrasounds) ;
- use of the operating room for surgery, anesthesia, and recovery room services; and
- other *hospital services* necessary for your treatment which we have approved.

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

MAINTENANCE SERVICES means any service that is intended to maintain current function, slow down, or prevent decline in function. *Maintenance services* are most often long term therapies that do not apply to persons with an acute chronic illness or functional deficit. See Section 4.34 - Supervision of Maintenance Therapy and Maintenance Services.

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

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

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

MAXIMUM OUT-OF-POCKET EXPENSE means the total amount of *copayments* that you must pay each *calendar year* for certain *covered health care services* provided by *network* and *non-network hospitals*, facilities, *doctors,* and other health care *providers.* The *network* and *non-network maximum out-of-pocket expenses* add up separately.

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

The *network* and *non-network* deductible is applied to the *network* and *non-network out of pocket maximum*.

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

MEDICALLY NECESSARY means that the health care services provided to treat your illness or injury, upon review by Blue Cross & Blue Shield of Rhode Island 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;
- not primarily for the convenience of the *member*, the *member's* family or *provider* of such *member;* AND
- the most appropriate supplies or level of service which can safely be provided to the *member*, i.e. no less expensive professionally acceptable alternative is available.

We will make a determination whether a health care service is *medically necessary.* You have the right to appeal our determination or to take legal action as described in Section 7.0. We review medical necessity on a case-by-case basis.

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

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

NEW SERVICE means a service, treatment, procedure, facility, equipment, drug, device, or supply we previously have not reviewed to determine if the service is eligible for coverage under this *agreement.*

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

OUTPATIENT is a patient receiving ambulatory care at a *hospital* or other health care facility. The patient is not admitted overnight.

PERSONAL PHYSICIAN means, for the purpose of this *agreement* and for the determination of your *copayment*, professional *providers* that are family practitioners, internists, and pediatricians. Nurse practitioners and physician assistants, practicing under the supervision of these professional *providers,* may be reimbursed as *personal physicians.* For the purpose of this *agreement*, gynecologists and obstetricians may be credentialed as *personal physicians* or as *specialist physicians*.

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

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

PREAUTHORIZATION is a process that determines if a health care service qualifies for benefit payment. The *preauthorization* process varies depending on whether the service is a medical procedure or a prescription drug. *Preauthorization* is not a guarantee of payment, as the process does not take benefit limits into account.

Preauthorization is the approval that we advise you to seek before receiving certain *covered health care services.* Selected prescription drugs bought at a pharmacy require *prescription drug preauthorization*. (See Section 3.27 for details.) *Preauthorization* ensures that services are *medically necessary* and performed in the most appropriate setting. *Network providers* are responsible for obtaining *preauthorization* for all applicable *covered health care services*.

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

You may ask for preauthorization by telephoning us. For *covered health care services* (other than behavioral health services), call our Customer Service Department at (401) 459-5000 or 1-800-639-2227.

For behavioral health services (mental health and *chemical dependency*), call (401) 277-1344 or 1-800-274-2958.

We must be contacted at least two (2) working days before you receive any *covered health care service* for which *preauthorization* is recommended.

Services for which *preauthorization* is recommended are marked with an asterisk (*) in the Summary of Medical Benefits.

PREVENTIVE CARE SERVICES means *covered health care services* performed to prevent the occurrence of disease. *S*ee Section 3.28 - *Preventive Care Services* and Early Detection Services.

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

PROVIDER means an individual or entity licensed under the laws of the State of Rhode Island or another state to furnish health care services. For purposes of this *agreement,* the term *provider* includes a *doctor* and a *hospital*. It also means individuals whose services we must cover under Title 27, Chapters 19 and 20 of the Rhode Island General Laws, as amended from time to time.

These individuals include:
- midwives;
- certified registered nurse practitioners;
- psychiatric and mental health nurse clinical specialists practicing in collaboration with or in the employ of a physician licensed in Rhode Island;
- counselors in mental health; and
- therapists in marriage and family practice.

REHABILITATIVE SERVICES means acute short-term therapies that can only be provided by a qualified professional. The therapies are used to treat functional deficiencies that are the result of injury or disease. Short-term therapies are services that result in measurable and meaningful functional improvements within sixty (60) days.

The services must be
- consistent with the nature and severity of illness;
- be considered safe and effective for the patient's condition;
- be used to restore function.

The *rehabilitative services* must be provided as part of a defined treatment plan for an acute illness, injury, or an acute exacerbation of a chronic illness with significant potential for functional recovery.

See Section 3.32 - Speech Therapy and the Summary of Medical Benefits for *benefit limits* and the amount that you pay.

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

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

SUBSCRIBER/MEMBER means you, the person listed on the application, which we agree to cover. Dependents (spouse, dependent children, etc.) are NOT covered under this *agreement*.

URGENT CARE CENTER means a health care center physically separate from a *hospital* or other institution with which it is affiliated. It may also mean an independently operated and owned health care center. These centers are also referred to as "walk-in centers".

UTILIZATION REVIEW means the prospective (prior to), concurrent (during) or retrospective (after) review of any service to determine whether such service was properly authorized, constitutes a *medically necessary* service for purposes of *benefit* payment, and is a *covered health care service* under this *agreement.*

- **Prospective Review** is a review done before services are rendered.
- **Concurrent Review** is a review done during a patient's *hospital* stay or course of treatment.
- **Retrospective Review** is a review done after services have been rendered.

WE, US, and **OUR** means Blue Cross & Blue Shield of Rhode Island. We are located at 500 Exchange Street, Providence, Rhode Island, 02903. In this agreement, WE, US, or OUR will have the same meaning whether italicized or not.

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

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