Benefit Booklet

State of Rhode Island
Value Plan
(Retired Employees)

Pursuant to Section 223 of the Internal Revenue Code (IRC), this *plan* qualifies as a *High Deductible Health Plan* (*HDHP*), which is suitable for use with a *Health Savings Account* (*HSA*). Any conflict between the terms of this policy and the provisions of Section 223 of the IRC will be resolved in favor of Section 223 of the IRC in order to preserve any potential tax benefits to the *subscriber*. This *plan* may be used in conjunction with an *HSA*, but it is not an *HSA* itself.

Administered by Blue Cross & Blue Shield of Rhode Island

Blue Cross Blue Shield of Rhode Island

STATE OF RHODE ISLAND
BENEFIT BOOKLET

TABLE OF CONTENTS

SUMMARY OF MEDICAL BENEFITS

This is a summary of your medical *benefits* under your State of Rhode healthcare *plan,* referred throughout *this benefit* booklet as the *"plan"*. It includes information about *copayments*, *deductibles*, and *benefit limits*. This summary is intended to give you a general understanding of the medical coverage available under this *plan*. Please read Section 3.0 for a detailed description of coverage for each *covered healthcare service* and Section 4.0 for exclusions.

The amount you pay for *covered healthcare services* can differ based on the following:

- the service was provided in an *inpatient* or *outpatient* setting, in a *physician's* office, or in your home;
- a *deductible*, a *copayment*, or a *benefit limit* applies to the service (see Summary of Medical Benefits for details);
- the healthcare *provider* is from a *network provider* or *non-network provider*;
- you reached your *plan year maximum out-of-pocket expense*;
- there are exclusions from coverage that apply; or
- our *allowance* for a *covered healthcare 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*.

Network Provider Services

If you receive *covered healthcare services* from a Retiree Anchor *Plan network provider*, the *provider* has agreed to accept our payment for *covered healthcare services* as payment in full, excluding your *copayments*, *deductible* (if any), and the difference between the *benefit limit* and our *allowance*, if any.

Non-network Provider Services

If you receive *covered healthcare services* from a *non-network provider*, you will be responsible for the *provider's charge*. The *deductible* and *maximum out-of-pocket expenses* are calculated based on the lower of our *allowance* or the *provider's charge*, unless special circumstances apply or otherwise specifically stated. For additional information about special circumstances and how we pay *non-network providers* please see Section 6.

Deductible/Maximum Out-of-Pocket Expense

Deductible; Maximum Out-of-Pocket Expense	**Network Providers**	**Non-network Providers**
	You Pay	**You pay**
Deductible -The amount you must pay each *plan year* before we begin to pay for certain *covered healthcare services*. See Glossary section for further details. The *deductible* applies to *network* and *non-network* services separately. Services that apply the *deductible* are indicated as "After *Deductible"* in the Summary of Medical *Benefits*.		
Deductible for an Individual Plan:	$2,000	$5,000
Deductible for a Family Plan: The Family *plan deductible* is met by adding the amount of *covered healthcare* expenses applied to the *deductible* for all family *members*.	$4,000	$10,000
Maximum Out-of-Pocket Expense - The total combined amount of your *deductible* and *copayments* you must pay each *plan year* for certain *covered healthcare services*. See Glossary section for further details. The *maximum out-of-pocket expense* limit accumulates separately for *network* and *non-network* services. The *deductible* and *copayments* from your medical *benefit plan* as well as the *copayments* from your pharmacy *benefit plan* apply to the *maximum out-of-pocket expense*.		
Maximum Out-of-Pocket Expense for an Individual Plan:	$4,000	$10,000
Maximum Out-of-Pocket Expense for a Family Plan: The family *maximum out-of-pocket expense* limit is met by adding the amount of *covered healthcare expenses* applied to the *maximum out-of-pocket expense* limit for all family *members*.	$8,000	$20,000

Summary of Medical Benefits

Covered Benefits - See Covered Healthcare Services for additional benefit limits and details.	**Network Providers**	**Non-network Providers**
(*) Preauthorization may be required for this service. Please see Preauthorization in Section 5 for more information.	**You Pay**	**You Pay**
Ambulance Services		
Ground	30% - After *deductible*	The level of coverage is the same as a *network provider*
Air/water*	30% - After *deductible*	The level of coverage is the same as a *network provider*
Autism Services		
Applied behavioral analysis Notification of services may be required.	30% - After *deductible*	50% - After *deductible*
Physical/Occupational/Speech Therapy Services - Autism Diagnosis - *Outpatient Hospital*	30% - After *deductible*	50% - After *deductible*
Physical/Occupational/Speech Therapy Services - Autism Diagnosis - In a *provider's* office	30% - After *deductible*	50% - After *deductible*
Behavioral Health Services – Mental Health and Substance Use Disorder		
Inpatient Hospital Unlimited days at a general *hospital* or a specialty *hospital* including withdrawal management (detoxification) per *plan year*. *Residential Treatment Facility* Unlimited days for residential mental health and substance use disorder services per *plan year*. Notification of admission may be required.	30% - After *deductible*	50% - After *deductible*
Outpatient or intermediate care services* - See Covered Healthcare Services: Behavioral Health Section for details about partial hospital program, intensive outpatient program, adult intensive services, and child and family intensive treatment. Notification of services may be required.	30% - After *deductible*	50% - After *deductible*
Office visits - See Office Visits section below for Behavioral Health services provided by a *PCP* or specialist.		
Psychological Testing	30% - After *deductible*	50% - After *deductible*
Medication-assisted treatment - when rendered by a mental health or substance use disorder *provider*.	30% - After *deductible*	50% - After *deductible*
Methadone maintenance treatment.	0% - After *deductible*	0% - After *deductible*
Cardiac Rehabilitation		
Outpatient - Benefit is limited to 18 weeks or 36 visits (whichever occurs first) per covered episode.	0% - After *deductible*	50% - After *deductible*
Cellular Immunotherapy (CAR-T) Services		
Services must be provided by *Blue Distinction Center network providers* in order to receive *network benefits*. See Cellular Immunotherapy (CAR-T) Services in Section 3 for details.	30% - After *deductible*	50% - After *deductible* The *benefit limit* is $30,000 for services received from a *non-network provider*.

Covered Benefits - See Covered Healthcare Services for additional benefit limits and details.	Network Providers	Non-network Providers
(*) Preauthorization may be required for this service. Please see Preauthorization in Section 5 for more information.	You Pay	You Pay
Chiropractic Services		
In a *physician's* office.	30% - After *deductible*	50% - After *deductible*
Congenital Heart Disease		
Services must be provided by *Blue Distinction Center network providers* in order to receive *network benefits*. See Congenital Heart Disease Services in Section 3 for details.	30% - After *deductible*	50% - After *deductible*
Dental Services - Accidental Injury (Emergency)		
Emergency room - When services are due to accidental injury to *sound natural teeth*.	30% - After *deductible*	The level of coverage is the same as a *network provider*.
In a *physician's/dentist's* office - When services are due to accidental injury to s*ound natural teeth*.	30% - After *deductible*	50% - After *deductible*.
Dental Services - Outpatient		
Services connected to dental care when performed in an *outpatient* facility *	30% - After *deductible*	50% - After *deductible*
Dialysis Services		
Inpatient/outpatient/in your home	30% - After *deductible*	50% - After *deductible*
Durable Medical Equipment (DME), Medical Supplies, Diabetic Supplies, Prosthetic Devices, and Enteral Formula or Food, Hair Prosthetics		
Outpatient durable medical equipment* - Must be provided by a licensed medical supply provider.	30% - After *deductible*	50% - After *deductible*
Outpatient medical supplies* - Must be provided by a licensed medical supply provider.	30% - After *deductible*	50% - After *deductible*
Outpatient diabetic supplies/equipment purchased at licensed medical supply *provider*.	30% - After *deductible*	50% - After *deductible*
Outpatient prosthesis* - Must be provided by a licensed medical supply provider.	30% - After *deductible*	50% - After *deductible*
Enteral formula delivered through a feeding tube. Must be sole source of nutrition.	30% - After *deductible*	50% - After *deductible*
Enteral formula or food taken orally *	30% - After *deductible*	The level of coverage is the same as a *network provider*.
Hair prosthesis (wigs) - when worn for hair loss suffered as a result of cancer treatment.	30% - After *deductible*	The level of coverage is the same as a *network provider*.
Early Intervention Services (EIS)		
Coverage provided for *members* from birth to 36 months. The *provider* must be certified as an EIS *provider* by the Rhode Island Department of Human Services.	0% - After *deductible*	The level of coverage is the same as a *network provider*.
Education - Asthma		
Asthma management	30% - After *deductible*	50% - After *deductible*
Emergency Room Services		
Hospital emergency room	30% - After *deductible*	The level of coverage is the same as a *network provider*.
Experimental and Investigational Services		
Coverage varies based on type of service.		
Gene Therapy		
Services must be provided by a *network provider* in order to be covered. See Gene Therapy Services in Section 3 for details.	30% - After *deductible*	Not Covered

Covered Benefits - See Covered Healthcare Services for additional benefit limits and details.	**Network Providers**	**Non-network Providers**
(*) Preauthorization may be required for this service. Please see Preauthorization in Section 5 for more information.	**You Pay**	**You Pay**
Hearing Services		
Hearing exam	30% - After *deductible*	50% - After *deductible*
Hearing diagnostic testing	30% - After *deductible*	50% - After *deductible*
Hearing aids - The *benefit limit* is per ear every 3 years, up to $4,000 in a *plan year.*	30% - After *deductible*	The level of coverage is the same as a *network provider.*
Home Health Care*		
Intermittent skilled services when billed by a home health care agency.	30% - After *deductible*	50% - After *deductible*
Hospice Care		
Inpatient/in your home. When provided by an approved hospice care program.	30% - After *deductible*	50% - After *deductible*
Human Leukocyte Antigen Testing		
Human leukocyte antigen testing	30% - After *deductible*	50% - After *deductible*
Infertility Services*		
*Inpatient/outpatient/*in a *physician's* office.	30% - After *deductible*	50% - After *deductible*
Infusion Therapy - Administration Services		
Outpatient - facility	30% - After *deductible*	50% - After *deductible*
In the *physician's* office/in your home	30% - After *deductible*	50% - After *deductible*
Inpatient Services		
General hospital or *specialty hospital* services* - Unlimited Days	30% - After *deductible*	50% - After *deductible*
Rehabilitation facility services* - Unlimited Days	30% - After *deductible*	50% - After *deductible*
Physician *hospital* visits	30% - After *deductible*	50% - After *deductible*
Mastectomy Services		
Inpatient - see Mastectomy Services in Section 3 for details.	0% - After *deductible*	50% - After *deductible.*
Surgery services - includes mastectomy and reconstructive surgery. See Mastectomy Services in Section 3 for details.	0% - After *deductible*	50% - After *deductible*
Mastectomy-related treatment - includes prostheses and treatment for physical complications.	0% - After *deductible*	50% - After *deductible*
Observation Services		
In a *hospital* or other health care facility	30% - After *deductible*	50% - After *deductible*
Office Visits - (Other than Preventive Care Services. See Prevention and Early Detection Services for coverage of annual preventive office visits.)		
Allergy injections - Applies to injection only, including administration.	0% - After *deductible*	50% - After *deductible*
Travel Immunizations – Includes injection and administration	0%	50% - After *deductible*
Hospital based clinic visits	30% - After *deductible*	50% - After *deductible*
PCP visits - including *behavioral health.* Visits include *PCP* office visits and *PCP* house calls and pediatric clinic visits.	30% - After *deductible*	50% - After *deductible*
Retail clinics	30% - After *deductible*	50% - After *deductible*
Specialists		
Office visits and house calls rendered by a specialist (other than a behavioral health specialist). Specialist includes but is not limited to allergists, dermatologists and podiatrists:	30% - After *deductible*	50% - After *deductible*

Covered Benefits - See Covered Healthcare Services for additional benefit limits and details.	**Network Providers**	**Non-network Providers**
(*) Preauthorization may be required for this service. Please see Preauthorization in Section 5 for more information.	**You Pay**	**You Pay**
Office visits and house calls rendered by a behavioral health specialist.	30% - After *deductible*	50% - After *deductible*
Organ and Tissue Transplant Services		
Inpatient transplant services for bone marrow/stem cell, heart, liver, lung, and pancreas must be provided at a *Blue Distinction Center network provider* in order to receive *network benefits*. See Organ and Tissue Transplant Services in Section 3 for details.	30% - After *deductible*	50% - After *deductible* The *benefit limit* is $30,000 per transplant for services received from a *non-network provider*.
Physical/Occupational Therapy		
*Outpatient hospital/in a physician's/*therapist's office.	30% - After *deductible*	50% - After *deductible*
Pregnancy and Maternity Services		
Pre-natal, delivery, and postpartum services.	30% - After *deductible*	50% - After *deductible*
Prescription Drugs and Diabetic Equipment and Supplies		
Prescription drugs and diabetic equipment and supplies purchased at a retail, specialty, or mail order pharmacy.	Not Covered	Not Covered
Prescription drugs requiring administration by a licensed health care *provider**:		
Prescription drugs other than infused drugs - includes but is not limited to: medications by injection or inhalation, as well as nasal, topical, or transdermal medications.	30% - After *deductible*	50% - After *deductible*
Infused drugs	30% - After *deductible*	50% - After *deductible*
Anti-neoplastic drugs used for cancer treatment* - Limited to injectable and infused anti-neoplastic drugs used for cancer treatment.	0% - After *deductible*	50% - After *deductible*
Prevention Care Services and Early Detection Services		
See Prevention and Early Detection Services section for details.	0%	50% - After *deductible*
Radiation Therapy/Chemotherapy Services		
Outpatient	30% - After *deductible*	50% - After *deductible*
In a *physician's* office	30% - After *deductible*	50% - After *deductible*
Respiratory Therapy		
Inpatient	0% - After *deductible*	50% - After *deductible*
Outpatient	0% - After *deductible*	50% - After *deductible*
Skilled Care in a Nursing Facility*		
Skilled or sub-acute care	30% - After *deductible*	50% - After *deductible*
Speech Therapy		
*Outpatient hospital/in a physician's/*therapist's office.	30% - After *deductible*	50% - After *deductible*
Surgery Services*		
Inpatient physician services	30% - After *deductible*	50% - After *deductible*
Outpatient services - includes *physician* services and *outpatient hospital* or *ambulatory surgical center* facility services.	30% - After *deductible*	50% - After *deductible*
In a *physician's* office	30% - After *deductible*	50% - After *deductible*

Covered Benefits - See Covered Healthcare Services for additional benefit limits and details.	**Network Providers**	**Non-network Providers**
(*) Preauthorization may be required for this service. Please see Preauthorization in Section 5 for more information.	**You Pay**	**You Pay**
Telemedicine Services		
When rendered by our designated telemedicine *provider.*	30% - After *deductible*.	Not Covered
When rendered by a *network provider* or *non-network provider* other than our designated telemedicine *provider*.	See the *covered healthcare service* being provided for the amount you pay	See *the covered healthcare service* being provided for the amount you pay
Tests, Labs, Imaging and X-rays - Diagnostic		
Outpatient, in a *physician's* office, *urgent care center* or free-standing laboratory:		
Major diagnostic imaging and testing including but not limited to: MRI, MRA, CAT scans, CTA scans, PET scans, nuclear medicine and cardiac imaging.	30% - After *deductible*	50% - After *deductible*
Sleep studies.*	30% - After *deductible*	50% - After *deductible*
Diagnostic imaging and tests, other than major diagnostic imaging and testing services noted above.	30% - After *deductible*	50% - After *deductible*
Lab and pathology services.	30% - After *deductible*	50% - After *deductible*
Diagnostic colorectal services - (Including, but not limited to, fecal occult blood testing, flexible sigmoidoscopy, colonoscopy, and barium enema. See Prevention and Early Detection Services for preventive colorectal services.)	30% - After *deductible*	50% - After *deductible*
Lyme disease		
Diagnosis	30% - After *deductible*	50% - After *deductible*
Treatment	Coverage varies based on the type of service being provided.	50% - After *deductible*
Urgent Care		
Urgent care services	30% - After *deductible*	50% - After *deductible*
Vision Care Services		
Vision exam - medically necessary	30% - After *deductible*	50% - After *deductible*

SECTION 1: INTRODUCTION TO YOUR BENEFIT BOOKLET

Welcome to Blue Cross & Blue Shield of Rhode Island (BCBSRI). We are the administrator for your State of Rhode Anchor healthcare *plan.* On behalf of the State of Rhode Island we are pleased to provide you with this *Benefit* Booklet.

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

- how your health coverage works;
- how BCBSRI processes *claims* for the health services you receive;
- your rights and responsibilities as a BCBSRI *member*;
- BCBSRI's rights and responsibilities; and
- tools and programs to help you stay healthy and save money.

We encourage you to read this *Benefit* Booklet to learn about all the advantages of being a *plan member*.

How to Use This Benefit Booklet

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

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

Contact Us If You Have a Question

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

Your Member Identification Card

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

Tips for keeping your card safe:

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

Your Guide to Selecting a Primary Care Provider (PCP) and Other Providers

Quality healthcare begins with a partnership between you and your *primary care provider* (*PCP*).

When you need care, call your *PCP*, who will help coordinate your care. Your healthcare coverage under this *Plan* is provided or arranged through our *network* of *PCPs*, specialists, and other *providers*. You're encouraged to:

- become involved in your healthcare by asking *providers* about all treatment plans available and their costs;
- take advantage of the preventive health services offered under this *Plan* to help you stay healthy and find problems before they become serious.

Each *member* is required to provide the name of his or her *PCP*. However, if the name of a *PCP* is not provided with the application, your enrollment will not be delayed and your coverage will not be cancelled.

How to Find a PCP or Other Providers

Finding a *PCP* in our *network* is easy. To select a *provider*, or to check that a *provider* is in our *network*, please use the "Find a Doctor" tool on our website or call the Employee CARE Center.

Please note: We are not obligated to provide you with a *provider*. We are not liable for anything your *provider* does or does not do. We are not a healthcare *provider* and do not practice medicine, dentistry, furnish health care, or make medical judgments.

Programs to Keep You Healthy

Many health problems can be prevented by making positive changes to your lifestyle, including exercising regularly, eating a healthy diet, and not smoking. As a *member*, you can take advantage of wellness programs at no additional cost.

This *Plan* may provide incentives or rewards for you to participate in these programs, as permitted by applicable state and federal law. These rewards may be taxable income.

Your participation in these wellness programs is voluntary. This *Plan* reserves the right to end wellness programs at any time.

Member Incentives
From time to time, this *Plan* may offer you coupons, discounts, or other incentives as part of our *member* incentives program. These coupons, discounts and incentives are not *benefits* and do not change or affect your *benefits* under this *plan*. You must be a *member* to be eligible for *member* incentives. Restrictions may apply to these incentives, and we reserve the right to change or stop providing *member* incentives at any time.

Care Coordination
Care coordination gives you access to dedicated BCBSRI healthcare professionals, including nurses, dietitians, behavioral health *providers*, and community resources specialists. These care coordinators can help you set and meet your health goals. You can receive support for many health issues, including, but not limited to:

- making the most of your *physician's* visits;
- navigating through the healthcare system;
- managing medications or addressing side effects;
- better understanding new or pre-existing medical conditions;
- completing preventive screenings;
- losing weight;
- accessing maternal health services, including doula services.

Care Coordination is a personalized service that is part of your existing healthcare coverage and is available at no additional cost to you. For more information, please call the Employee CARE Center or visit our website.

Disease Management
If you have a chronic condition such as asthma, coronary heart disease, diabetes, congestive heart failure, and/or chronic obstructive pulmonary disease, we're here to help. Our tools and information can help you manage your condition and improve your health. You may also be eligible to receive help through our care coordination program. This voluntary program is available at no additional cost you. To learn more about disease management, please call the Employee CARE Center.

Transportation and Lodging Reimbursement Program

When you receive treatment for a *covered healthcare service* listed below and you live more than 50 miles from the *network provider*, you may receive coverage for transportation and lodging costs (when the treatment being received extends more than one day). Reimbursement for transportation and lodging costs for travel to a *non-network provider* is not covered unless prior approval is provided by us.

This additional coverage for transportation and lodging is available for the *member* who is receiving the *covered healthcare services* and one companion, as described below. If the *member* receiving the *covered healthcare service* is an enrolled minor dependent, then the transportation and lodging costs of two companions are covered.

Covered Healthcare Service	**Maximum Lifetime *Benefit* Per *Member*** - while *member* is covered under this *plan*.
Organ and Tissue Transplants – Limited to *inpatient* services. Certain transplant services must be provided at a Blue Distinction Center *network provider* in order to receive *network benefits*. See Organ and Transplant Services in Section 3 for a list of these transplant services and additional information.	$5,000
Cancer Treatments	$10,000
Obesity Surgery Services	$5,000

Transportation

Reimbursement for transportation costs are provided for the following:

- Automobile mileage for the most direct route between the patient's home and the provider (reimbursement is based on the IRS medical rate);
- Taxi or cab fares;
- Airfare (economy or coach);
- Trains, boats, buses;
- Parking or tolls.

Lodging

Lodging costs are reimbursed up to $50 per day for the *member* (when not in the *hospital*) or a companion, with a combined reimbursement limit of $100 per day, for the patient (when not in the *hospital*) and one caregiver. For a minor dependent member, two companions may be covered, with a reimbursement limit of $100 per day. Coverage is provided for lodging only. Items such as groceries, meals and other personal items are not covered.

Receipts for transportation and lodging expenses must be submitted to us in order to be reimbursed. Reimbursed expenses may be taxable income. Once the per-day maximum *benefit* payments and/or lifetime *benefit limit* maximums have been reached, no more *benefits* will be provided for these costs.

To determine if you are eligible for this program please call the Employee CARE Center.

About This Benefit Booklet

BCBSRI provides administrative *claims* payment services only and does not assume any financial risk or obligation with respect to *claims*.

This benefit booklet describes the *benefits*, exclusions, conditions and limitations provided under your *plan*. It shall be construed under and shall be governed by applicable laws and regulations. It replaces any benefit booklet previously issued to you.

SECTION 2: ELIGIBILITY

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

Who Is an Eligible Person

You

You are eligible to enroll in coverage effective as of your date of hire if you are a full-time employee scheduled to work at least twenty (20) hours per week. Please contact the State of Rhode Island Office of Employee Benefits in the Department of Administration for additional eligibility information

Your Spouse

If your *plan* includes family coverage*,* your spouse is eligible to enroll for healthcare coverage if you have selected a family *plan*. Please the OEB, as they may request more information from you to confirm eligibility.

Only one of the following individuals may be enrolled at a given time:
- Your legal spouse: according to the laws of the state in which you were married.
- Your common law spouse: according to the law of the state in which your marriage was formed and the State's eligibility rules as determined by the OEB.
- Domestic Partner: according to RI Gen. Laws §36-12-1 and the State's eligibility rules as determined by OEB. You and your domestic partner will be required to complete a form and provide the required documentation listed on the form. Please contact the OEB for any additional information regarding coverage for domestic partners.
- Former Spouse: according to RI Gen. Laws §36-12-2.5 and the State's eligibility rules as determined by OEB.

Your Children

Each of your and your spouse's children are eligible for coverage until the last day of the month in which they turn twenty-six (26). Please contact the OEB, as they may request more information from you to confirm your child's eligibility.

For purposes of determining eligibility for coverage, the term children means:
- Natural children;
- Step-children;
- Legally adopted children;
- Foster children who have been placed with you by an authorized placement agency or court order.

A child for whom healthcare coverage is required through a Qualified Medical Child Support Order or other court or administrative order is also eligible for coverage. The OEB is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

Disabled Dependents
When your enrolled unmarried child reaches the maximum dependent age of twenty-six (26), he or she can continue to be considered an eligible dependent only if he or she is determined by OEB to be a disabled dependent.

Please contact the OEB to obtain the necessary form to verify the child's disabled status. Periodically you may be asked to submit additional documents to confirm the child's disabled status.

When Your Coverage Begins

Your coverage will begin on the first day of your eligibility date in accordance with the State's eligibility rules as determined by the OEB.

If you fail to enroll yourself or your dependents at this time, you cannot enroll in the *Plan* unless you do so through an Open Enrollment Period or a Special Enrollment Period.

Open Enrollment Period
Open Enrollment is a period of time each year when you and your eligible dependents may enroll for healthcare coverage or make changes to your existing healthcare coverage. The effective date will be on the first day of your employer's *plan year*.

Special Enrollment Period
A Special Enrollment Period is a time outside the yearly Open Enrollment Period when you can sign up for health coverage. You and your eligible dependents may enroll for coverage through a Special Enrollment Period by providing required enrollment information within thirty-one (31) days of the following events:

- you get married.
- you have a child born to the family.
- you have a child placed for adoption with your family.

Special Enrollment If You Are Pregnant
If you are a pregnant individual, you are eligible to enroll for coverage at any time after the commencement of your pregnancy. Coverage will be effective the first of the month in which we receive your application for enrollment.

The OEB can provide you information regarding effective dates of coverage.

In addition, if you lose coverage from another *plan*, you may enroll or add your eligible dependents for coverage through a Special Enrollment Period by providing required enrollment information within thirty-one (31) days following the date you lost coverage. Coverage will begin on the first day of the pay period following the date your coverage

under the other *plan* ended. In order to be eligible, the loss of coverage must be the result of:

- legal separation or divorce;
- death of the covered policy holder;
- termination of employment or reduction in the number of hours of employment;
- the covered policy holder becomes entitled to Medicare;
- loss of dependent child status under the *plan*;
- employer contributions to such coverage are being terminated;
- COBRA *benefits* are exhausted; or
- your employer is undergoing Chapter 11 proceedings.

You are also eligible for a Special Enrollment Period if you and/or your eligible dependent lose eligibility for Medicaid or a Children's Health Insurance Program (CHIP), or if you and/or your eligible dependent become eligible for premium assistance for Medicaid or a (CHIP). In order to enroll, you must provide required information within sixty (60) days following the change in eligibility. Coverage will begin on the first day of the pay period following the date eligibility was gained/lost as described immediately above.

In addition, if you or your dependent lose minimum essential coverage (unless that loss of coverage is due to non-payment of premium or your voluntary termination of coverage) you may be eligible for a Special Enrollment Period if you provide required information within thirty-one (31) days from the date your coverage ended.

Coverage for Members Who Are Hospitalized on Their Effective Date

If you are in the *hospital* on your effective date of coverage, healthcare services related to such hospitalization are covered as long as they are received in accordance with the terms, conditions, exclusions and limitations of this *plan*. You should notify us of your hospitalization within forty-eight (48) hours of the effective date, or as soon as is reasonably possible. As always, *benefits* paid in such situations are subject to the Coordination of *Benefits* provisions.

How to Add or Remove Coverage for Family Members

Notify the OEB if you want to add or remove family members according to the Special Enrollment provisions described above. When adding or removing a family member, inform the OEB in advance of the requested effective date and the OEB will notify us. All requests must be made through the OEB. We cannot directly add or remove coverage for you or your family members.

When Your Coverage Ends

Coverage under this *Plan* is guaranteed renewable. It can only be canceled for the following reasons:

- if you leave your place of employment;
- if you decide to discontinue coverage.
- if you or a covered dependent no longer qualifies as an eligible person;
- if we no longer offer this type of coverage;

- if another insurer or entity is contracted to provide or administer *benefits* for the *covered healthcare services* provided by this *Plan*;
- if you fail to pay the required premium while on an unpaid leave of absence;
- if you receive one year of State-subsidized coverage while on an approved personal illness leave of absence;
- if you receive two years of State-subsidized coverage while on a leave of absence due to a work-related injury/illness and for which you are receiving worker's compensation benefits;
- if fraud is determined by us. See Rescission of Coverage section below for additional details.

When your coverage ends, you may apply for individual healthcare coverage directly from BCBSRI or through *HSRI*. You must meet the eligibility requirements and we must receive required enrollment information within sixty (60) days from the date your group coverage ended along with required premium. If you do not reside in Rhode Island, you are not eligible to enroll in an individual *plan* from BCBSRI or *HSRI*. You may be able to obtain coverage through an insurance company in the state in which you reside.

Rescission of Coverage
Rescission is a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation is not a rescission if it:

- only has a prospective effect (as described above); or
- is due to non-payment, which can have a retroactive cancellation effect.

We may rescind your coverage if you or your dependents commit fraud. Fraud includes, but is not limited to, intentional misuse of your identification card (ID card) or intentional misrepresentation of a material fact. Any *benefit* paid in the past will be voided. You will be responsible to reimburse us for all costs and *claims* paid by us. We must provide you a written notice of a rescission at least thirty (30) days in advance.

Continuation of Coverage

If your coverage is terminated, you may be eligible to continue your coverage in accordance with state or federal law.

Continuation of Coverage According to State Law
In accordance with R.I. General Laws § 27-19.1, if your employment is terminated due to one of the following reasons, your healthcare coverage may be continued, provided that you continue to pay the applicable premiums.

- Involuntary layoff or death;
- The workplace ceasing to exist; or
- Permanent reduction in size of the workforce.

The period of this continuation will be for up to eighteen (18) months from your termination date, but not to exceed the period of continuous employment preceding termination with your employer. The continuation period will end for any person covered under your policy on the date the person becomes employed by another group and is eligible for *benefits* under that group's *plan*.

Extended Benefits

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

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

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

- the continuous disability ends; or
- twelve (12) months from the termination date; or
- payment of the *benefit limits* under this *Plan*.

Continuation of Coverage According to Federal Law

If coverage for you or your covered dependents is terminated and your coverage was made available through a group health *plan*, you may be eligible for continuation of coverage according to federal law. This law is the Consolidated Omnibus Budget Reconciliation Act of 1986 as amended from time to time (“COBRA”). Workterra, the COBRA administrator for this *Plan*, is responsible for making COBRA coverage available to you, and for complying with all of COBRA’s requirements. You should contact them if you have any questions about continuing coverage through COBRA.

SECTION 3: COVERED HEALTHCARE SERVICES

This section describes *covered healthcare services*. This *Plan* covers services only if they meet all of the following requirements:

- Listed as a *covered healthcare service* in this section. The fact that a *provider* has prescribed or recommended a service, or that it is the only available treatment for an illness or injury does not mean it is a *covered healthcare service* under this *plan*.
- *Medically necessary*, consistent with our medical policies and related guidelines at the time the services are provided.
- Not listed in Exclusions Section.
- Received while a *member* is enrolled in the *plan*.
- Consistent with applicable state or federal law.

We review *medical necessity* in accordance with our medical policies and related guidelines. Our medical policies can be found on our website.

Our 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 *physician*. If you have questions about our medical policies, please call the Employee CARE Center.

When a *new service* or drug becomes available, when possible, we will review it within six (6) months of one of the events described below to determine whether the *new service* or drug will be covered:

- the assignment of an American Medical Association (AMA) Current Procedural Terminology (CPT) code in the annual CPT publication;
- final Food and Drug Administration (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 above; and
- generally, the first date an FDA approved prescription drug is available.

During the review period, *new services* and drugs are not covered.

For all *covered healthcare services*, please see the Summary of Medical *Benefits* to determine the amount that you pay and any *benefit limits*.

Ambulance Services

Ground Ambulance

This *Plan* covers local professional or municipal ground ambulance services when it is *medically necessary* to use these services, rather than any other form of transportation. Examples include but are not limited to the following:

- from a *hospital* to a home, a skilled nursing facility, or a rehabilitation facility after being discharged as an *inpatient*;
- to the closest available *hospital emergency* room in an *emergency* situation; or
- from a *physician's* office to an *emergency* room.

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

Air and Water Ambulance
This *Plan* covers air and water ambulance services 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; or
- if the proper equipment needed to treat the patient is not available from a ground ambulance.

The patient must be transported to the nearest facility where the required services can be performed and the type of *physician* needed to treat the patient's condition is available.

Our *allowance* for the air or water ambulance includes the services rendered by an *emergency* medical technician or paramedic, as well as any drugs, supplies and cardiac monitoring provided.

Autism Services

This *Plan* covers the following services for the treatment of autism spectrum disorders.

- Applied behavior analysis when provided and/or supervised by an individual licensed by the state in which the service is rendered. See the Summary of Medical *Benefits* for the amount that you pay.

- Physical therapy, occupational therapy, and speech therapy services when rendered as part of the treatment of autism spectrum disorder. A *benefit limit* will not apply to these services.

- Psychological and psychiatric services, and prescription drugs, if applicable, are also covered. See Behavioral Health Services and Prescription Drugs for additional information.

Coverage for autism spectrum disorders does not affect any obligation of a school district, a state or other governmental entity to provide services to an individual under an individualized family service *plan*, an individualized education program, or similar services required under state or federal law. Services related to autism that are furnished by school personnel are not covered under this *plan*.

Behavioral Health Services

Behavioral health services include the evaluation, management, and treatment for a mental health or *substance use disorder* condition. For the purpose of this *plan*, *substance* use *disorder* does not include addiction to or abuse of tobacco and/or caffeine.

Mental health or *substance* use *disorders* are those that are listed in 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 (ICD) published by the World Health Organization.

This *Plan* provides parity in *benefits* for behavioral *healthcare* services. Please see Section 10 for additional information regarding behavioral *healthcare* parity.

For *inpatient hospital* and intermediate care services described below, *network providers* are responsible for submitting notification of admission to us. When these services are received from *non-network providers* you are responsible for ensuring notification of admission has been provided to us. In many cases, the *non-network provider* may submit the notification on your behalf. However, prior to receiving these services, please check with your *provider* to ensure notification has been made.

Inpatient

Hospital

This *plan* covers behavioral health services if you are *inpatient* at a general or *specialty hospital*. See *Inpatient* Services in Section 3 for additional information.

Residential Treatment Facility

This *plan* covers services at behavioral health *residential treatment facilities*, which provide:

- clinical treatment;
- medication evaluation management; and
- 24-hour on site availability of health professional staff, as required by licensing regulations.

Intermediate Care Services

This *Plan* covers intermediate care services, which are facility-based *programs* that are:

- more intensive than traditional *outpatient* services;
- less intensive than 24-hour *inpatient hospital* or *residential treatment facility* services; and
- used as a step down from a higher level of care; or
- used a step-up from standard care level of care.

Intermediate care services include the following:

- **Partial Hospital Program (PHP)** – PHPs are structured and medically supervised day, evening, or nighttime treatment *programs* providing individualized treatment plans. A PHP typically runs for five hours a day, five days per week.
- **Intensive Outpatient Program (IOP)** – An IOP provides substantial clinical support for patients who are either in transition from a higher level of care or at risk for admission to a higher level of care. An IOP typically runs for three hours per day, three days per week.
- **Home and Community Based Adult Intensive Service (AIS) and Child and Family Intensive Treatment (CFIT)** – AIS/CFIT *programs* offer services primarily based in the home and community for qualifying adults and children with moderate-to-severe mental health conditions. These *programs* consist at a minimum of ongoing *emergency*/crisis evaluations, psychiatric assessment, medication evaluation and management, case management, psychiatric nursing services, and individual, group, and family therapy.

In a Provider's Office/In Your Home

This *plan* covers individual psychotherapy, group psychotherapy, and family therapy when rendered by:

- Psychiatrists;
- Licensed Clinical Psychologists;
- Licensed Independent Clinical Social Workers;
- Advance Practice Registered Nurses (Clinical Nurse Specialists/Nurse Practitioners-Behavioral Health);
- Licensed Mental Health Counselors; and
- Licensed Marriage and Family Therapists.

Psychological Testing

This *Plan* covers psychological testing as a behavioral health *benefit* when rendered by:

- neuropsychologists;
- psychologists; or
- pediatric neurodevelopmental specialists.

This *Plan* covers neuropsychological testing as described in the Tests, Labs and Imaging section.

Medication Assisted Treatment

This *Plan* covers medication assisted treatment for *substance* us*e disorders*, including methadone maintenance treatment. Please see the Summary of Medical *Benefits* for specific *copayments* for these services.

Cardiac Rehabilitation

This *Plan* covers services provided in a cardiac rehabilitation *program* up to the *benefit limit* shown in the Summary of Medical *Benefits*.

Cellular Immunotherapy (CAR-T) Services

This *Plan* covers services for cellular immunotherapy or CAR-T cell therapy. *Covered healthcare services* must be provided at a *Blue Distinction Center network provider* for you to receive *network benefits*. When these services are received from *any provider* other than a *Blue Distinction Center network provider,* you will receive *non-network benefits.*

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

To find a *Blue Distinction Center network provider* please use the "Find a Doctor" tool on our website or contact the Employee CARE Center.

Chiropractic Services

This *Plan* covers chiropractic visits.

Congenital Heart Disease Services

This *Plan* covers services related to congenital heart disease. *Covered healthcare services* must be provided at a *Blue Distinction Center network provider* for you to receive *network benefits*. When these services are received from *any provider* other than a *Blue Distinction Center network provider* you will receive *non-network benefits.*

To find a *Blue Distinction Center network provider* please use the "Find a Doctor" tool on our website or contact the Employee CARE Center.

Dental Services

Services to Treat an Accidental Injury

This *Plan* covers the following services to treat an accidental injury to your *sound natural teeth* or an injury resulting in a facial fracture, received in an *emergency* room or *provider's* office when the treatment is received within seventy-two (72) hours of the injury.

- 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.

Outpatient Dental Anesthesia Services

This *Plan* covers anesthesia services received in connection with a dental service when provided in a *hospital* or *freestanding ambulatory surgical center* and:

- the use of this is *medically necessary*; and
- the setting in which the service is received is determined to be appropriate.

This *plan* also covers facility fees associated with these services.

Dialysis Services

This *Plan* covers dialysis services and supplies provided when you are *inpatient*, *outpatient* or in your home and under the supervision of a dialysis *program*. Dialysis supplies provided in your home are covered as durable medical equipment.

Durable Medical Equipment (DME), Medical Supplies, Prosthetic Devices, Enteral Formula or Food, and Hair Prosthesis (Wigs)

This *Plan* covers durable medical equipment and supplies, prosthetic devices and enteral formula or food as described in this section.

Durable Medical Equipment (DME)

DME is 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.

DME includes supplies necessary for the effective use of the equipment

This *Plan* covers the following DME:

- wheelchairs, *hospital* beds, and other DME items used only for medical treatment; and
- replacement of purchased equipment which is needed due to a change in your medical condition or if the device is not functional, no longer under warranty, or cannot be repaired.

DME may be classified as a rental item or a purchased item. In most cases, this *Plan* only pays for a rental DME up to our *allowance* for a purchased DME. Repairs and supplies for rental DME are included in the rental *allowance*.

Preauthorization may be required for certain DME and replacement or repairs of DME.

Medical Supplies

Medical supplies are consumable supplies that are disposable and not intended for re-use. Medical supplies require an order by a *physician* and must be essential for the care or treatment of an illness, injury, or congenital defect.

Covered medical supplies include:

- essential accessories such as hoses, tubes and mouthpieces for use with *medically necessary* DME (these accessories are included as part of the rental *allowance* for rented DME);
- catheters, colostomy and ileostomy supplies, irrigation trays and surgical dressings; and
- respiratory therapy equipment.

Diabetic Equipment and Supplies
This *Plan* covers diabetic equipment and supplies for the treatment of diabetes. Covered diabetic equipment and supplies include:

- therapeutic or molded shoes and inserts for custom-molded shoes for the prevention of amputation;
- blood glucose monitors including those with special features for the legally blind, external insulin infusion pumps and accessories, insulin infusion devices and injection aids; and
- lancets and test strips for glucose monitors including those with special features for the legally blind, and infusion sets for external insulin pumps.

In addition to purchasing the below equipment and supplies from a durable medical equipment *provider*, for this *Plan* the following diabetic equipment and supplies may be purchased from a pharmacy.

- glucometers;
- test strips;
- lancet and lancet devices;
- needles and syringes; and
- miscellaneous supplies (including calibration fluid).

Coverage for some diabetic equipment and supplies listed above may only be available from either a DME *provider* or from a pharmacy. Visit our website to determine if this is applicable or call the Employee CARE Center. See the Summary of Medical *Benefits* for the amount you pay.

Prosthetic Devices
Prosthetic devices replace or substitute all or 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 and alleviate functional loss or impairment due to an illness, injury or congenital defect. Prosthetic devices do not include dental prosthetics.

This *Plan* covers the following prosthetic devices:

- prosthetic appliances such as artificial limbs, breasts, larynxes and eyes;
- replacement or adjustment of prosthetic appliances 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 prosthetic devices;
- orthopedic braces except corrective shoes and orthotic devices used in connection with footwear; and
- breast prosthesis following a mastectomy, in accordance with the Women’s Health and Cancer Rights Act of 1998.

The prosthetic device must be ordered or provided by a *physician*, or by a *provider* under the direction of a *physician*. When you are prescribed a prosthetic device as an *inpatient* and it is billed by a *provider* other than the *hospital* where you are an *inpatient*, the *outpatient benefit limit* will apply.

Enteral Formulas or Food (Enteral Nutrition)
Enteral formula or food is nutrition that is absorbed through the intestinal tract, whether delivered through a feeding tube or taken orally. Enteral nutrition is covered when it is the sole source of nutrition and prescribed by the *physician* for home use.

This *Plan* covers 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.

Food products modified to be low protein are covered for the treatment of inherited diseases of amino acids and organic acids. *Preauthorization* may be required.

The amount that you pay may differ depending on whether the nutrition is delivered through a feeding tube or taken orally. When enteral formula is delivered through a feeding tube, associated supplies are also covered.

Hair Prosthesis (Wigs)
This *plan* covers hair prosthetics (wigs) worn for hair loss suffered as a result of cancer treatment.

Early Intervention Services (EIS)
This *Plan* covers Early Intervention Services. Early Intervention Services are educational, developmental, health, and social services provided to children from birth to thirty-six (36) months. The child must be certified by the Rhode Island Department of Human Services (DHS) 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.

Members not living in Rhode Island may seek services from the state in which they reside; however, those services are not covered under this *plan*.

Early Intervention Services as defined by DHS include but are 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.

Education - Asthma

This *Plan* covers asthma education services when the services are prescribed by a *physician* and performed by a certified asthma educator.

Emergency Room Services

This *plan* covers services received in a *hospital emergency* room or an *independent freestanding emergency department* when needed to stabilize or initiate treatment in an *emergency*. If your condition needs immediate or urgent, but non-*emergency* care, contact your *PCP* or use an *urgent care center*.

This *plan* covers bandages, crutches, canes, collars, and other supplies incidental to your treatment in the *emergency* room as part of our *allowance* for the *emergency* room services.

Additional services provided in the *emergency* room or an *independent freestanding emergency department* such as radiology or *physician* consultations are covered separately from *emergency* room services and may require additional *copayments*. The amount you pay is based on the type of service being rendered.

Follow-up care services, such as suture removal, fracture care or wound care, received at the *emergency* room will require an additional *emergency* room *copayment*. Follow-up care services can be obtained from your *primary care provider* or a specialist.

See Dental Services in Section 3 for information regarding *emergency* dental care services.

Experimental or Investigational Services

This *Plan* covers certain *experimental or investigational* services as described in this section.

Clinical Trials

This *Plan* covers clinical trials. An approved clinical trial is a phase I, phase II, phase III, or phase IV clinical trial that is being performed to prevent, detect or treat cancer or a life-threatening disease or condition. In order to qualify, the clinical trial must be:

- federally funded;
- conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or
- a drug trial that is exempt from having such an investigational new drug application.

To qualify to participate in a clinical trial:

- you must be determined to be eligible, according to the trial protocol;
- a *network provider* must have concluded that your participation would be appropriate; and
- medical and scientific information must have been provided establishing that your participation in the clinical trial would be appropriate.

If a *network provider* is participating in a clinical trial, and the trial is being conducted in the state in which you reside, you may be required to participate in the trial through the *network provider*.

Coverage under this *Plan* includes routine patient costs for *covered healthcare services* furnished in connection with participation in a clinical trial. The amount you pay is based on the type of service you receive.

Coverage for clinical trials does not include:
- the investigational item, device, or service itself;
- items or services provided solely to satisfy data collection and that are not used in the direct clinical management; or
- a service that is clearly inconsistent with widely accepted standards of care.

Off-label Prescription Drugs
This *Plan* covers off label prescription drugs for cancer or disabling or life-threatening chronic disease if the prescription drug is recognized as a treatment for cancer or disabling or life-threatening chronic disease in accepted medical literature.

Gender Affirming Services
This *plan* covers gender affirming services. *Preauthorization* may be required for gender affirming surgical services.

Gene Therapy Services
This *Plan* covers gene therapy for inherited ocular disorders only. *Covered healthcare services* must be provided by a *network provider.* If you receive these services from a *non-network provider* the service is not covered*.*

Hearing Services
Hearing Exams and Tests
This *Plan* covers hearing exams and diagnostic hearing tests.

Hearing Aids
This *Plan* covers hearing aids, subject to the *benefit limit* and *copayments* listed in the Summary of Medical *Benefits*.

We will reimburse the lesser of the *provider's charge* or the *benefit limit* shown in the Summary of Medical *Benefits*. If the *provider's charge* is more than the *benefit limit*, you are responsible for paying any difference. See Section 6 for additional information.

Home Health Care
This *Plan* covers the following home care services when provided by a certified home healthcare agency:
- nursing services;
- services of a home health aide;
- visits from a social worker;

- medical supplies; and
- physical, occupational and speech therapy.

Hospice Care

If you have a terminal illness and you agree with your *physician* not to continue with a curative treatment *program*, this *Plan* covers hospice care services received in your home, in a skilled nursing facility, or in an *inpatient* facility.

Human Leukocyte Antigen Testing

This *Plan* covers human leukocyte antigen testing for A, B, and DR antigens once per *member* per lifetime to establish a ***member's*** bone marrow transplantation donor suitability.

The testing must be performed in a facility that 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 that also authorizes the results of the test to be used for participation in the National Marrow Donor *program*.

Infertility Services

This *Plan* covers the following services.

- Services for the diagnosis and treatment of infertility if you are a presumably healthy individual; and unable to conceive or sustain a pregnancy during a one (1) year period.

- Standard fertility preservation services for members not in active infertility treatment when a medically necessary medical treatment may directly or indirectly cause iatrogenic infertility. Iatrogenic infertility means an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

Preauthorization may be required for certain infertility services.

Infusion Therapy

This *Plan* covers infusion therapy and related administration services.

Inpatient Services

Hospital

This *Plan* covers services provided while *inpatient* in a general or *specialty hospital* including, but not limited to the following:
- anesthesia;
- diagnostic tests and lab services;

- dialysis;
- drugs;
- intensive care/coronary care;
- nursing care;
- physical, occupational, speech and respiratory therapies;
- *physician's* services while hospitalized;
- radiation therapy;
- surgery related services; and
- room and board.

Notify us if you are admitted from the *emergency* room to a *hospital* that is not in our *network*. The Employee CARE Center can assist you with any questions you may have about your coverage.

Rehabilitation Facility
This *Plan* covers rehabilitation services received in a *general hospital* or *specialty hospital*. Coverage is limited to the number of days shown in the Summary of Medical *Benefits*.

Physician Visits
This *Plan* covers the services of a *physician* or other *provider* in charge of your medical care while you are *inpatient* in a general or *specialty hospital*.

Mastectomy Services

Inpatient
This *Plan* 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.

Surgery Services and Mastectomy Related Treatment
This *Plan* provides *benefits* for mastectomy surgery and mastectomy-related services in accordance with the Women's Health and Cancer Rights Act of 1998. For the *member* receiving mastectomy-related *benefits*, coverage will be provided in a manner determined in consultation with the attending *physician, physician* assistant, or an advance practice registered nurse 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.

See the Summary of Medical *Benefits* for the amount you pay.

Observation Services

This *Plan* covers services provided to you when you are in a *hospital* or other licensed health care facility solely for observation. Even though you may use a bed or stay overnight, observation services are not *inpatient* services.
Observation services help the *physician* decide if you need to be admitted for care as an *inpatient* or if you can be discharged. These observation services may be provided in the *emergency* room or another area of the *hospital* or licensed healthcare facility. See the Summary of Medical *Benefits* for the amount you pay.

Office Visits (other than Preventive Care Services)

This *Plan* covers office and clinic visits to diagnose or treat a sickness or injury. Office visit *copayments* differ depending on the type of *provider* you see.

This *Plan* covers *physician* visits in your home if you have an injury or illness that:

- confines you to your home; or
- requires special transportation; and
- because of this injury or illness, you are physically unable to travel to the *provider's* office.

If you receive services other than the office or clinic visit examination, such as surgery, lab tests, diagnostic imaging, physical or occupational therapy, the amount that you pay is based on the type of service provided.

For *Preventive Care Services* see the Summary of Medical *Benefits* for the amount you pay when these services are provided in a *physician's* office or clinic.

Organ Transplants

This *Plan* covers organ and tissue transplants when ordered by a *physician*, is *medically necessary*, and is not an *experimental or investigational* procedure.

Examples of covered transplant services include but are not limited to: heart, heart-lung, lung, liver, small intestine, pancreas, kidney, cornea, small bowel, and bone marrow.

Inpatient transplant services for the following conditions must be provided at a *Blue Distinction Center network provider* in order to receive *network benefits*. This list may be subject to change. Please see our website or contact the Employee CARE Center.

- Bone marrow/stem cell;
- Heart;
- Liver;
- Lung; and
- Pancreas.

When these services are received from any *provider* other than a *Blue Distinction Center network provider* you will receive *non-network benefits.*

Allogenic bone marrow transplant *covered healthcare 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*. For details see Human Leukocyte Antigen Testing section.

This *Plan* covers high dose chemotherapy and radiation services related to autologous bone marrow transplantation. See *Experimental or Investigational* Services in Section 3 for additional information.

The national transplant network program is called the *Blue Distinction Centers* for Transplants.℠ For more information about the *Blue Distinction Centers* for Transplants℠ or additional information about transplant services, please call the Employee CARE Center or visit our website.

When the recipient is a covered *member* under this *plan*, the following services are also covered:

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

This *Plan* may cover travel and lodging costs when the transplant services are provided at a *Blue Distinctions Center*. See Transportation and Lodging Reimbursement Program in Section 1 for details.

Pediatric Neuropsychiatric Disorder Services

This *plan* covers services for the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute onset neuropsychiatric syndrome (PANS). Treatment includes but is not limited to the use of intravenous immunoglobin therapy.

Preauthorization may be required for certain services to treat PANDAS or PANS. The amount you pay depends on the *covered healthcare service* you receive, as indicated in the Summary of Medical *Benefits*.

Physical/Occupational Therapy

This *Plan* covers physical and occupational therapy when:

- ordered by a *physician*;
- received from a licensed physical or occupational therapist;
- a *program* is implemented to provide *habilitative* or *rehabilitative* services.

See Autism Services when physical therapy and occupational therapy services are rendered as part of the treatment of autism spectrum disorder.

The amount you pay will be the same whether the services are provided for *habilitative* or *rehabilitative* purposes.

Pregnancy and Maternity Services

This *Plan* covers *physician* services and the services of a licensed midwife for prenatal, delivery, and postpartum care. The first office visit to diagnose a pregnancy is not included in prenatal services.

This *Plan* covers *hospital* services for mother and newborn child for at least forty-eight (48) hours following a vaginal delivery and ninety-six (96) hours following a caesarean delivery.
The newborn child's coverage includes necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, as well as routine well-baby care services.

Abortion Services

This *Plan* covers abortion services in the case of rape or incest, or for a pregnancy which places the woman in danger of death unless an abortion is performed (i.e., abortions for which federal funding is allowed). *Preauthorization* may be required.

Prescription Drug Services

A. Prescription Drugs Purchased at a Pharmacy

With the exception of the prescription drugs covered as a medical *benefit* listed below, this *plan* does not cover prescription drugs when purchased at a retail or mail order pharmacy. Please refer to your Prescription Drug Plan document for coverage information.

B. Medical Benefits - Prescription Drugs Administered by a Provider (other than a pharmacist)

This *plan* covers prescription drugs as a medical *benefit*, referred to as "*medical prescription drugs"*, when the prescription drug requires administration (or the FDA approved recommendation is administration) by a licensed healthcare *provider* (other than a pharmacist). Please note: Certain prescription drugs meeting these requirements or recommendations that are designated as a specialty prescription drug are not covered as a medical *benefit*.

These *medical prescription drugs* include, but are not limited to, medications administered by infusion, injection, or inhalation, as well as nasal, topical or transdermal administered medications. For some of these *medical prescription drugs*, the cost of the prescription drug is included in the *allowance* for the medical service being provided, and is not separately reimbursed.

Prescription drugs are covered when dispensed using the following guidelines:

- the prescription must be *medically necessary*, consistent with the *physician's* diagnosis, ordered by a *physician* whose license allows him or her to order it, and filled according to state and federal laws;
- the prescription must consist of *legend drugs* that require a *physician's* prescription under law, or compound medications made up of at least one *legend drug* requiring a *physician's* prescription under law;
- the prescription must be dispensed at the proper place of service as determined by our Pharmacy and Therapeutics Committee; and
- the prescription is limited to the quantities authorized by your *physician*.

Administration Services

When a *medical prescription drug* is administered by infusion, the administration of the prescription drug may be covered separately from the prescription drug. See Infusion Therapy - Administration Services in the Summary of Medical *Benefits* for *benefit limits* and the amount you pay.

Prescription drugs that are self-administered are not covered as a medical *benefit*.

Site of Care Program

For some *medical prescription drugs*, after the first administration, coverage may be limited to certain locations (for example, a designated *outpatient* or ambulatory service facility, *physician's* office, or your home), provided the location is appropriate based on your medical status. For a list of *medical prescription drugs* that are subject to this Site of Care Program, visit our website.

Preauthorization may be required to determine *medical necessity* as well as appropriate site of care. If we deny your request for *preauthorization*, or you disagree with our determination for the appropriate site of care, you can submit a medical appeal. See Appeals in Section 5 for information on how to file a medical appeal.

Designated Prescription Drug Prescribers

We may limit your selection a single prescribing *provider* or practice. Those *members* subject to this designation include, but are not limited to, *members* that have a history of:

- being prescribed prescription drugs by multiple *providers*;
- being prescribed certain long-acting opioids and other controlled substances, either in combination or separately, that suggests a need for monitoring due to:
  - quantities dispensed;
  - daily dosage range; or
  - the duration of therapy exceeds reasonable and established thresholds.

Medical Prescription Drug Coverage Exception Process
When a *medical prescription drug* is not covered, you can request that this *plan* cover the drug as an exception.

To request a coverage exception, complete a Coverage Exception form (located on our website), contact our Customer Service Department, or have your prescribing *provider* submit a request for you. We will respond to you with a determination within seventy-two (72) hours following receipt of the request. For standard exception reviews, if the exception is approved, we will cover the prescription drug for the duration of the prescription, including refills.

How to Request an Expedited Medical Prescription Drug Coverage Exception Review
You may request an expedited review if a delay could significantly increase the risk to your health or your ability to regain maximum function, or you are undergoing a current course of treatment with a drug not on our *formulary*. Please indicate "urgent" on the Coverage Exception form or inform Customer Service of the urgent nature of your request. We will respond to you with a determination within twenty-four (24) hours following receipt of the request. For expedited exception reviews, if the exception is approved, we will cover the prescription drug for the duration of the exigency.

For both standard and expedited exception reviews, if we grant your request for a *medical prescription drug* coverage exception, the amount you pay will be the prescription drugs *copayment* shown in the Summary of Medical *Benefits*. Other applicable *benefit* requirements are not waived by this exception and must be reviewed separately.

If we deny your request for a *medical prescription drug* coverage exception, we will notify you with information on how to appeal our decision, including external appeal information.

Preventive Care and Early Detection Services

This *plan* covers, early detection services, *preventive care services*, and immunizations or vaccinations in accordance with federal law, including the Affordable Care Act (ACA), as set forth below and in accordance with 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); or
- preventive care and screenings for women as outlined in the comprehensive guidelines as supported by HRSA.

Covered early detection services, *preventive care services* and adult and pediatric immunizations or vaccinations are based on the most currently available guidelines and are subject to change.

The amount you pay for preventive services will be different from the amount you pay for diagnostic procedures and non-preventive services. See the Summary of Medical *Benefits* for more information about the amount you pay.

Preventive Office Visits
This *Plan* covers the following preventive office visits.

- Annual preventive visit - one (1) routine physical examination per *plan year* per *member* age 36 months and older;
- Pediatric preventive office and clinic visits from birth to 35 months - 11 visits;
- Well Woman annual preventive visit - one (1) routine gynecological examination per *plan year* per female *member*.

Health and Diet Counseling
This *Plan* covers diabetes and nutritional counseling in accordance with state and federal laws, when prescribed by a *physician* and provided by either a *physician* or an appropriately licensed, registered or certified counselor.

This *Plan* covers smoking cessation *programs* when prescribed by a *physician* or, upon his or her referral, by a qualified licensed practitioner.

Vaccinations/Immunizations
This *Plan* covers adult and pediatric preventive vaccinations and immunizations in accordance with current guidelines. Our *allowance* includes the administration and the vaccine. If a covered immunization is provided as part of an office visit, the office visit *copayment* and *deductible* (if any) will apply.

Preventive Screening/Early Detection Services
This *Plan* covers preventive screenings based on the ACA guidelines noted above. Preventive screenings include but are not limited to:

- mammograms;
- pap smears;
- prostate-specific antigen (PSA) tests;
- flexible sigmoidoscopy;
- double contrast barium enema;
- fecal occult blood tests, screening for gestational diabetes, and human papillomavirus; and
- genetic counseling for breast cancer susceptibility gene (BRCA).

This *plan* covers colonoscopies. *Covered healthcare services* include an initial colonoscopy or other medical tests or procedures for colorectal cancer screening and a follow-up colonoscopy if the results of the initial test are abnormal.

Contraceptive Methods and Sterilization Procedures for Women
This *Plan* covers the following contraceptive services:

- FDA approved contraceptive drugs and devices requiring a prescription;
- barrier method (cervical cap, diaphragm, or implantable) fitted and supplied during an office visit; and
- surgical and sterilization services for women with reproductive capacity, including but not limited to tubal ligation.

Breastfeeding Counseling and Equipment
This *Plan* covers lactation (breastfeeding) support and counseling during the pregnancy or postpartum period when provided by a licensed lactation counselor. This *plan* covers manual, electric, or battery operated breast pumps for a female *member* in conjunction with each birth event.

Covid-19 Tests and Vaccinations
This *plan* covers Covid-19 tests and vaccinations without *copayments* in accordance with federal requirements.

Radiation Therapy/Chemotherapy Services

This *Plan* covers chemotherapy and radiation services.

Respiratory Therapy

This *Plan* covers respiratory therapy services. When respiratory services are provided in your home, as part of a home care *program*, durable medical equipment, supplies, and oxygen are covered as a durable medical equipment service.

Skilled Care in a Nursing Facility

This *Plan* covers skilled nursing services in a skilled nursing facility if:

- the services are prescribed by a *physician*:
- your condition needs skilled nursing services, skilled rehabilitation services or skilled nursing observation;
- the services are provided by or supervised by licensed technical or professional medical personnel; and
- the services are not custodial care, respite care, day care, or for the purpose of assisting with activities of daily living.

Speech Therapy

This *Plan* covers speech therapy services when provided by a qualified licensed *provider* and part of a formal treatment plan for:

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

Speech therapy services must relate to:

- performing basic functional communication; or
- assessing or treating swallowing dysfunction.

See Autism Services when speech therapy services are rendered as part of the treatment of autism spectrum disorder.

The amount you pay will be the same whether the services are provided for *habilitative* or *rehabilitative* purposes.

Surgery Services

This *Plan* covers surgery services to treat a disease or injury when:

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

Preauthorization may be required for certain surgical services.

Reconstructive Surgery for a Functional Deformity or Impairment

This *Plan* covers reconstructive surgery and procedures when the services are performed to relieve pain, or to correct or improve bodily function that is impaired as a result of:

- a birth defect;
- an accidental injury;
- a disease; or
- a previous covered surgical procedure.

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

This *Plan* covers the procedures listed below to treat functional impairments.

- 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;
- treatment of varicose veins; or
- gynecomastia.

Preauthorization may be required for these services.

Anesthesia Services

This *Plan* covers general and local anesthesia services received from an anesthesiologist when the surgical procedure is a *covered healthcare service*.

This *plan* covers office visits or office consultations with an anesthesiologist when provided prior to a scheduled covered surgical procedure.

Telemedicine Services

This *plan* covers clinically appropriate telemedicine services when the service is provided via remote access through an on-line service or other interactive audio and video telecommunications system.

Clinically appropriate telemedicine services may be obtained from a *network* or *non-network provider*, and from our designated telemedicine service *provider*.

When you seek telemedicine services from our designated telemedicine service *provider*, the amount you pay is listed in the Summary of Medical *Benefits*.

When you receive a *covered healthcare service* from a *network* or *non-network provider* via remote access, the amount you pay depends on the *covered healthcare service* you receive, as indicated in the Summary of Medical *Benefits*.

For information about telemedicine services, our designated telemedicine service provider, and how to access telemedicine services, please visit our website or contact our Customer Service Department.

Tests, Labs, and Imaging and X-rays (diagnostic)

This *Plan* covers diagnostic tests, labs, and imaging and x-rays to diagnose or treat a condition when ordered by a *physician*.

Major Diagnostic Imaging and Tests

Major diagnostic imaging and tests include but are not limited to:

- magnetic resonance imaging (MRI),
- magnetic resonance angiography (MRA),
- computerized axial tomography (CAT or CT scans),
- nuclear scans,
- positron emission tomography (PET scan), and
- cardiac imaging.

MRI examinations conducted outside of the State of Rhode Island must be performed in accordance with the applicable laws of the state in which the examination has been conducted.

Diagnostic Imaging and X-rays (other than the imaging services noted above)

Diagnostic imaging and x-rays include but are not limited to:

- general imaging (such as x-rays and ultrasounds), and
- mammograms.

Tests

Diagnostic tests include but are not limited to:

- electrocardiograms (EKGs),

- electroencephalograms (EEGs),
- nerve conduction tests,
- neuropsychological testing, and
- sleep studies.

Labs and Pathology
Diagnostic labs and pathology include but are not limited to:
- blood tests,
- urinalysis,
- pap smears, and
- throat cultures.

For tests, labs and imaging associated with *Preventive Care Services* and Early Detection Services, please refer to that section, and see the Summary of Medical *Benefits* for the amount you pay.

Lyme Disease Diagnosis and Treatment
This *Plan* covers diagnostic testing and long-term antibiotic treatment of chronic lyme disease. To be covered, services must be ordered by your *physician* after evaluation of your symptoms, diagnostic test results, and response to treatment. Coverage for lyme disease treatment will not be denied solely because such treatment may be characterized as unproven, experimental, or investigational.

Urgent Care
This *Plan* covers services received at an *urgent care center*. For other services, such as surgery or diagnostic tests, the amount that you pay is based on the type of service being provided. See Summary of Medical *Benefits* for details.

Follow-up care (such as suture removal or wound care) should be obtained from your *primary care provider* or specialist.

Please note: *Retail clinics* located in retail stores, supermarkets and pharmacies are not considered *urgent care centers*. The amount you pay for services at a retail based clinic differs from the amount you pay for urgent care services. See the Summary of Medical *Benefits* for details.

Vision Care Services
Eye Exam
This *Plan* covers eye examinations to treat a medical condition.

SECTION 4: EXCLUSIONS

This section lists the services or categories of services that are not covered (excluded) under this *plan*. We will not cover services listed in this section even if they are prescribed or recommended by your *provider*. We will not cover services that are not *medically necessary*, whether or not they are listed in this section.

The exclusion headings in this section are intended to group together services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath each heading.

The services listed in this section are not covered under this *plan*.

Air and Water Ambulance Services

- Air or water ambulance transportation services, when the destination is not to 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.

Behavioral Health Services

- Non-medical self-care, or self-help training (e.g. Alcoholics Anonymous (AA), Narcotics Anonymous (NA) meetings/services).
- Behavioral training assessment, education, or exercise services unless provided for applied behavioral analysis.
- Psychoanalysis for educational purposes, regardless of symptoms.
- Psychotherapy services you may receive which are credited towards a degree or to further your education or training.

Chiropractic Services

- Chiropractic services received in your home.

Dental Services

The following dental services are not covered, except as described under Dental Services in Section 3:

- Dental injuries incurred as a result of biting or chewing.
- General dental services including, but not limited to, extractions including full mouth extractions, prostheses, braces, operative restorations, fillings, frenectomies, 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.
- Panorex x-rays or dental x-rays.
- Orthodontic services, even if related to a covered surgery.
- Dental appliances or devices.
- Preparation of the mouth for dentures and dental or oral surgeries such as, but not limited to, the following:
    - 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; and
- vestibuloplasty with skin/mucosal graft and lowering the floor of the mouth.

Dialysis Services

- The following dialysis services received in your home:
  - 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; and
  - training in the operation of the dialysis machine when the training in the operation of the dialysis machine is billed as a separate service.
- Dialysis services received in a *physician's* office.

Durable Medical Equipment (DME), Medical Supplies, Prosthetic Devices, and Enteral Formula or Food

- 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.
- DME and medical supplies prescribed primarily for the convenience of the *member* or the *member's* family, including but not limited to, duplicate DME or medical supplies for use in multiple locations or any DME or medical supplies used primarily to assist a caregiver.
- Non-wearable automatic external defibrillators.
- Replacement of durable medical equipment and prosthetic devices prescribed because of a desire for new equipment or new technology.
- Equipment that does not meet the basic functional need of the average person.
- DME that does not directly improve the function of the *member*.
- Medical supplies provided during an office visit.
- Pillows or batteries, except when used for the operation of a covered prosthetic device, or items for which the sole function is to improve the quality of life or mental wellbeing.

- Repair or replacement of DME when the equipment is under warranty, covered by the manufacturer, or during the rental period.
- Infant formula, nutritional supplements and food, or food products, whether or not prescribed, unless required by R.I. Law §27-20-56 for Enteral Nutrition Products, or delivered through a feeding tube as the sole source of nutrition.
- Corrective or orthopedic shoes and orthotic devices used in connection with footwear, unless for the treatment of diabetes.

Experimental or Investigational Services

- Treatments, procedures, facilities, equipment, drugs, devices, supplies, or services that are *experimental or investigational* except as described in Section 3.

Gender Affirming Services

- Reversal of gender affirming surgery.

Hearing Services

- Repairs, modifications, cords, batteries, and other assistive listening devices.

Home Health Care

- Homemaking, companion, chronic, or custodial care services.
- Services of a personal care attendant.

Infertility Services

- Freezing, storage and thawing of embryos, sperm, or other tissues, for future use, unless the freezing, storage and thawing is needed due to potential iatrogenic infertility as described in Infertility Services in Section 3.
- Reversal of voluntary sterilization or infertility treatment for a person that previously had a voluntary sterilization procedure.
- Fees associated with finding an egg or sperm donor, related storage, donor stipend, or shipping *charges*.
- Services related to surrogate parenting, when the surrogate is not a *member* of this *Plan.*

Inpatient Services

- *Hospital* services which are not performed in a *hospital*.

Organ Transplants

- Medical services of the donor that are not directly related to the organ transplant.
- Services related to obtaining, storing, or other services performed for the potential future use of umbilical cord blood.
- Non-cadaveric small bowel transplants.
- Services related to donor searches.
- Donor related medical and surgical expenses when the recipient is not covered as a *member*.
- Services or supplies related to an excluded transplant procedure.

Pregnancy and Maternity Services

- Preimplantation genetic diagnosis, also known as embryo screening.
- Amniocentesis or any other service when performed solely to determine gender.
- Abortions except in the case of rape or incest, or for a pregnancy which places the woman in danger of death unless an abortion is performed.
- Services related to surrogate parenting or the newborn child of the surrogate parent, when the surrogate is not a *member* of this *Plan.*

Prescription Drugs and Diabetic Equipment or Supplies

- Prescription drugs and diabetic equipment or supplies when purchased at any type pharmacy. Please refer to your Prescription Drug Plan document for coverage information.
- Prescription drugs prescribed or dispensed outside of our dispensing guidelines.
- Prescription drugs ordered or prescribed based solely on online questionnaires, telephonic interviews, surveys, emails, or any other marketing solicitation methods, whether alone or in combination.
- Prescription drugs that have not proven effective according to the FDA.
- Prescription drugs used for cosmetic purposes.
- Experimental prescription drugs including those placed on notice of opportunity hearing status by the Federal Drug Efficacy Study Implementation (DESI).Off-label use of prescription drugs except as described in *Experimental or Investigational* Services in Section 3;
- Prescribed weight-loss drugs.
- Prescription drugs, therapeutic equivalents, or any other pharmaceuticals used to treat sexual dysfunctions.
- Prescription drugs and *specialty prescription drugs* when the required prescription drug *preauthorization* is not obtained.
  Illegal drugs, including medical marijuana, which are dispensed in violation of state and/or federal law.

Private Duty Nursing Services

- Services of a private duty nurse or nurse's aide.

Surgery Services

- Abdominoplasty.
- Brow ptosis surgery.
- Cervicoplasty.
- Chemical exfoliations, peels, abrasions, 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 for panniculectomy.

- Genioplasty.
- Hair transplants.
- Hair removal including electrolysis epilation, unless in relation to gender affirming services or skin grafting.
- Inverted nipple surgery.
- Laser treatment for acne and acne scars.
- 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.
- Skin tag removal.
- Subcutaneous injection of filling material.
- Suction assisted Lipectomy.
- Tattooing or tattoo removal except tattooing of the nipple/areola related to a mastectomy.
- Treatment of vitiligo.
- Standby services of an assistant surgeon or anesthesiologist.
- Orthodontic services related to orthognathic surgery.
- Cosmetic procedures when performed primarily:
    - to refine or reshape body structures or dental 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.

Tests, Labs, and Imaging and X-rays (diagnostic)

- Re-reading of diagnostic tests by a second *provider*.
- Dental x-rays except when ordered by a *physician*/*dentist* to diagnose a condition due to an accident to your *sound natural teeth*.
- 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.
- Nicotine lab tests.
- Parental testing.
- Forensic testing.

Therapies

- Acupuncture and acupuncturist services, including x-ray and laboratory services.
- Biofeedback, biofeedback training, and biofeedback by any other modality for any condition.
- Recreational therapy services and *programs*, including wilderness *programs*.
- Services provided in any covered *program* that are recreational therapy services, including wilderness *programs*, educational services, complimentary services, non-medical self-care, self-help *programs*, or non-clinical services. Examples include, but are not limited to, Tai Chi, yoga, personal training, meditation.
- Computer/internet/social media based services and/or *programs*.
- Aqua therapy unless provided by a physical therapist.
- Maintenance therapy services unless it is a *habilitative service* that helps a person keep, learn or improve skills and functioning for daily living.
- Aromatherapy.
- Hippotherapy.
- Massage therapy rendered by a massage therapist.
- Therapies, procedures, and services for the purpose of relieving stress.
- Physical, occupational, speech, or respiratory therapy provided in your home, unless through a home care *program*.
- Pelvic floor electrical and magnetic stimulation, and pelvic floor exercises.
- Educational classes and services for speech impairments that are self-correcting.
- Speech therapy services related to food aversion or texture disorders.
- Exercise therapy.
- Naturopathic, homeopathic, and Christian Science services, regardless of who orders or provides the services.

Vision Care Services

- Eye exercises and visual training services, including computer-based vision training.
- Lenses and/or frames and contact lenses unless specifically listed as a *covered healthcare service*.
- Routine eye exams.

Providers

- 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 (https://exclusions.oig.hhs.gov/) or the Excluded Parties List System website maintained by the U.S. General Services Administration (https://www.sam.gov/).
- Services provided by facilities, *dentists*, *physicians*, surgeons, or other *providers* who are not legally qualified or licensed, according to relevant sections of Rhode Island Law or other governing bodies, or who have not met our credentialing requirements.
- Services provided by a *non-network provider*, unless listed as covered in the Summary of Medical *Benefits*.
- Services provided by naturopaths, homeopaths, or Christian Science practitioners.

Services Available or Provided from Other Sources

- Services for any condition, illness, or disease which should be covered by the United States government or any of its agencies, any state or municipal government or any of its agencies except *emergency* care when there is a legal responsibility to provide it.
- Services or supplies for military-related conditions, such as war, or any military action, which takes place after your coverage becomes effective.
- Services received in a facility mainly meant to care for students, faculty, or employees of a college or other institution of learning.
- *Covered healthcare services* provided to you when there is no *charge* to you or there would have been no *charge* to you absent this health *plan*.
- Services if another entity or agency is responsible under state or federal laws, which are provided for the health of schoolchildren or children with disabilities. See also applicable regulations about the health of schoolchildren and the special education of children with disabilities or similar rules set forth by federal law or state law of applicable jurisdiction.
- Services and supplies which are required under the laws of a state, other than Rhode Island, and are not provided under this health *plan*.

All Other Exclusions

- Services not approved by the FDA or other governing body.
- Services we have not reviewed or we have not determined are eligible for coverage.
- Services obtained through fraud or intentional misrepresentation.
- Administrative service *charges* for:
  - missed appointments;
  - completion of *claim* forms;
  - additional fees, sometimes referred to as access fees, associated with concierge, boutique, or retainer practices; and
  - any other administrative *charges*.
- Blood services for drawing, processing, or storage of your own blood, including any penalty fees related to blood services.
- Continuation of a *covered healthcare service* or *benefit* as a result of a clerical error.
- Custodial care, rest care, day care, or non-skilled care services.
- Convalescent homes, nursing homes including non-skilled care, assisted living facilities, or other residential facilities.
- Educational classes, unless listed as covered, and training services.
- Exams or services that are required for or related to employment, education, marriage, adoption, insurance purposes, court order, or similar third parties when not *medically necessary* or when the *benefit limit* for the exam or service has been met.
- 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 *members* with a systemic condition such as metabolic, neurologic, or peripheral vascular disease.
- Treatment of flat feet unless the treatment is a covered surgical service.

- Telephone consultations, telephone services, or medication monitoring by phone, except for clinically appropriate telemedicine services as described in Section 3.
- Healthcare services for work-related illnesses or injuries for which *benefits* are available under Workers' Compensation , whether or not you are entitled to such *benefits*, unless:
  - you are self-employed, a sole stockholder of a corporation, or a member of a partnership; and
  - your illnesses 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 another employer.
- Services and supplies used for your personal appearance and/or comfort, whether or not prescribed by a *physician* and regardless of your condition. These services and supplies include, but are not limited to:
  - batteries, unless indicated as covered;
  - radio;
  - telephone;
  - television;
  - air conditioner;
  - humidifier;
  - dehumidifier
  - air purifier;
  - beauty and barber services;
  - recliner lift;
  - travel expenses, whether or not prescribed by a *physician (except as described in the Transportation and Lodging Reimbursement Program in Section 1)*;
  - raised toilet seats;
  - toilet seat systems;
  - cribs;
  - ramps;
  - positioning wedges;
  - wall or ceiling mounted lift systems;
  - water circulating cold pads or cryo-cuffs;
  - car seats including any vest system or car beds;
  - bath or shower chair systems;
  - trampolines;
  - tricycles;
  - therapy balls; and
  - net swings with a positioning seat.
- Repatriation and medical evacuation services for transportation back to the United States from another country. This exclusion does not apply to air and water ambulance services as described in Section 3, which provides for transportation to the nearest facility where the required services can be performed.
- Research studies.
- Self-treated services or services provided by relatives whether by blood, marriage, or adoption, or other members of your household.

- Services related to sexual dysfunctions, except *medically necessary* services for treatment related to an organic condition.
- *Programs* or drugs designed for the purpose of weight loss, including but not limited to, commercial diet plans, weight loss *programs*, and any services in connection with such plans or *programs*.
- Health assessment *programs* designed to provide personalized treatment plans. These treatment plans can include but are not limited to:
  - cardiovascular assessments;
  - diet;
  - exercise; and
  - lifestyle guidance.

SECTION 5: REQUESTS FOR AUTHORIZATION, DENIALS, COMPLAINTS, AND APPEALS

Requests for Authorization

We evaluate the *medical necessity* of select *covered healthcare services* using clinical criteria to facilitate clinically appropriate, cost-effective management of your care. This process is called *utilization review*, and it can occur in the following situations:

- When you (or your *provider*) request authorization for a service before receiving it (*preauthorization*).
- When you (or your *provider*) request authorization for a service that is already initiated or ongoing (concurrent authorization).
- When you (or your *provider*) request authorization for a service you have already received (retrospective authorization).

The determination of whether a service is *medically necessary* is solely for the purpose of *claims* payment and the administration of health *benefits* under this *plan*. It is not an exercise of professional medical judgment. BCBSRI does not act as a healthcare *provider*. We do not furnish medical care. You are not prohibited from having a treatment or hospitalization for which reimbursement was not authorized. Nothing here will change or affect your relationship with your *provider(s)*.

We may contract with an organization to conduct *utilization review* on our behalf. That organization may contact you about your request for authorization.

Preauthorization

Preauthorization is the process by which we determine whether a *covered healthcare service* is *medically necessary* before you receive the service. Medical services which may require *preauthorization* are marked with an asterisk (*) in the Summary of Medical *Benefits*.

Preauthorization is not a guarantee of payment, as the process does not take other coverage requirements into account, such as *benefit limits*, the amount you pay, or eligibility.

In most cases, *providers* are responsible for obtaining *preauthorization* for *covered healthcare services*. However, in some cases you are responsible for ensuring a *preauthorization* has been obtained prior to receiving *a covered healthcare service*. Please check with your *provider* for assistance with obtaining the *preauthorization*. The chart below describes who is responsible for ensuring a *preauthorization* has been obtained:

Covered services provided by:	Preauthorization is the responsibility of the:
Network Providers	*Provider*
Non-Network Providers	*Member*
BlueCard Providers: *Inpatient* Services Other Services	 *Provider* *Member*

For mental health and *substance* use *disorder* services received from *non-network providers*, please call 1-800-274-2958 prior to receiving care. For all other *covered healthcare services*, call the Employee CARE Center.

A notification of the *preauthorization* determination will be provided prior to the date of service but no later than fourteen (14) calendar days from receipt of the request.

When we determine that the services are not *medically necessary*, that service is not covered. If the *provider* is responsible for obtaining *preauthorization*, that *provider* may not bill you for the service. When you are responsible for obtaining *preauthorization*, and we determine the service is not *medically necessary*, you will be responsible for the cost of the services. You have the right to appeal our determination or to take legal action as described in this section.

Please note: You do not need *preauthorization* for *emergency* services. Additionally, you do not need *preauthorization* from us or from any other person (including a *PCP*) in order to obtain access to obstetrical or gynecological care from a *network physician* who specializes in obstetrics or gynecology. Your *physician*, however, may be required to comply with certain procedures, including obtaining *preauthorization* for certain services.

Expedited Preauthorization
You may request an expedited *preauthorization* review in an *emergency*. We will respond to you with a determination within seventy-two (72) hours following receipt of the request.

Concurrent Authorization
We review requests for concurrent authorization when you need an extension of an authorized course of treatment beyond the period of time or number of treatments already approved. If we deny your request, we will notify your *provider* before the end of the treatment period and will let you know within twenty-four (24) hours from receipt of the request if the request is made at least twenty-four (24) hours before the expiration of the period of time or number of treatments. You have the right to appeal our determination or to take legal action as described in this section.

Retrospective Authorization
We review requests for retrospective authorization when services were provided before authorization was obtained. A notification of the retrospective determination will be provided within thirty (30) calendar days from receipt of the request. You have the right to appeal our determination or to take legal action as described in this section.

Network Authorization
For services that cannot be provided by a *network provider*, you can request a *network authorization* to seek services from a *non-network provider*. With an approved *network authorization*, the *network benefit* level will apply to the authorized *covered healthcare service*. If we approve a *network authorization* for you to receive services from a *non-network provider*, our reimbursement will be based on the lesser of our *allowance*, the *non-network provider's charge*, or the *benefit limit.* For more information, please see the How *Non-Network Providers* Are Paid section.

Denials

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

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

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

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

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

Complaints

A complaint is an expression of dissatisfaction with any aspect of our operation or the quality of care you received from a healthcare *provider*. A complaint is not an appeal. For information about submitting an appeal, please see the Reconsiderations and Appeals section below.

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

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

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

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

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

Reconsiderations and Appeals

If you experience a problem relating to an authorization review, *benefit* denial, or other aspect of this *plan*, we have internal and external procedures to help you resolve your issue.

The following sections detail the processes and procedures for filing:
- Administrative Appeals;
- Medical Reconsiderations and Appeals (including expedited appeals);
- Prescription Drug Appeals: and
- External Appeals.

For appeals of a decision that a *medical prescription drug* is not covered, please see the *Medical Prescription Drug* Coverage Exception Process in the Prescription Drug section.

When filing a reconsideration or an appeal, please provide the same information listed in the Complaints section above.

Administrative Appeals

An administrative appeal is a request for us to reconsider a full or partial denial of payment for *covered healthcare services* for the following reasons:
- the services were excluded from coverage;
- we determined that you were not eligible for coverage;
- you or your *provider* did not follow BCBSRI's requirements; or
- a limitation on an otherwise covered *benefit* exists.

You are not required to file a complaint (as described above), before filing an administrative appeal. If you call the Employee CARE Center, a Customer Service Representative will try to resolve your concern. If the issue is not resolved to your satisfaction, you may file a verbal or written administrative appeal with our Grievance and Appeals Unit.

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

The Grievance and Appeals Unit will conduct a thorough review of your administrative appeal and respond within:

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

The letter will provide you with information regarding our determination.

Medical Reconsiderations and Appeals

A medical reconsideration or appeal is a request for us to reconsider a full or partial denial of payment for *covered healthcare services* because we determined:

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

You may request an expedited appeal when:

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

How to File a Medical Request for Reconsideration

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

If someone other than your provider is requesting a medical reconsideration on your behalf, you must provide us with a signed notice, authorizing the individual to represent you in this matter. For additional information about confidentiality of your healthcare information see “Our Right to Receive and Release Information About You” in Section 10.

- You will receive written notification of our determination within fifteen (15) calendar days from the receipt of your request for reconsideration of a prospective, concurrent, or retrospective review.

How to File an Appeal of a Medical Reconsideration
You may request an appeal if our denial was upheld during the initial reconsideration. Your appeal will be reviewed by a *provider* in the same or similar specialty as your treating *provider*. You must submit your request for an appeal within forty-five (45) calendar days of receiving of the reconsideration denial letter.

You will receive written notification of our appeal determination following the same timeframes noted in the How to File a Medical Request for Reconsideration section above.

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

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

To request an expedited appeal of a denial related to services that have not yet been rendered (a *preauthorization* review) or for on-going services (a concurrent review), you or your healthcare *provider* should call:
- our Grievance and Appeals Unit; or
- our *medical prescription drug benefits* manager for a *medical prescription drug* appeal.

Please see Section 9 for contact information.

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

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

How to Request an External Appeal
If you remain dissatisfied with our medical appeal determination, you may request an external review by an outside review agency. Your our external appeal will be reviewed by one of the external independent review organizations (IRO) approved by the Office of the Health Insurance Commissioner. The IRO is selected using a rotational method.
You may also request an external appeal by an outside agency if you are dissatisfied with our appeal determination related to any of the following special circumstances as described in more detail in Section 6:

- *Emergency* room services;
- Air ambulance services;

- Non-emergency *covered healthcare services* rendered by a *non-network provider* at certain *network* facilities.

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

Your *claim* does not have to meet a minimum dollar threshold and there is no filing fee charged to you when requesting an external appeal.

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

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

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

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

Legal Action

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

In accordance with R.I. Gen. Laws § 27-18-3, 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*.

For *members* covered by a group (employer sponsored) health *plan*, your *Plan* may be subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Under federal law, if your *Plan* is subject to ERISA you may have the right to bring legal action under section 502(a) of ERISA after you have exhausted all appeals available under the *plan*. That means, for both medical and administrative appeals, federal law requires that you pursue a final decision from the *plan*, prior to filing suit under section 502(a) of ERISA. For a medical appeal, that final decision is the determination of the appeal. You are not required to submit your *claim* to external review prior to filing a suit under section 502(a) of ERISA. Consult your employer to determine whether this applies to you and what your rights and obligations may be. 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.

SECTION 6: CLAIM FILING AND PROVIDER PAYMENTS

This section provides information regarding how a *member* may file a *claim* for a *covered healthcare service and how* we pay *providers* for a *covered healthcare service*.

How to File a Claim

Network providers file *claims* on your behalf.

Non-network providers may or may not file *claims* on your behalf. If a *non-network provider* does not file a *claim* on your behalf, you will need to file it yourself. In order to be reimbursed you need to complete a non-network claim form and include proof of payment or you may also send us the *provider's* itemized bill, and include the following information:

- your name;
- your *member* ID 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.

A non-network claim form may be obtained by contacting the Employee CARE Center. Please send your *claim* to the address listed in the Contact Information section.

Claims must be filed within one calendar year of the date you receive a *covered healthcare service*. *Claims* submitted after this deadline are not eligible for reimbursement. This timeframe does not apply if you are legally incapacitated.

How Network Providers Are Paid

We pay *network providers* directly for *covered healthcare services*. *Network providers* agree not to bill, *charge*, collect a deposit from, or seek reimbursement from you for a *covered healthcare service*, except for your share under the *plan*.

When you see a *network provider*, you are responsible for a share of the cost of *covered healthcare services*. Your share includes the *deductible*, if one applies, and the *copayment*, as listed in the Summary of Medical *Benefits*. The *covered healthcare service* may also have a *benefit limit*, which caps the amount we will reimburse the *provider* for that service. You will be responsible for any amount over the *benefit limit*, up to the *allowance*.

Your *provider* may request these payments at the time of service, or may bill you after the service. If you do not pay your *provider*, the *provider* may decline to provide current or future services or may pursue payment from you, such as beginning collection proceedings.

Some of our agreements with *network providers* include alternative payment methods such as incentives, risk-sharing, care coordination, value-based, capitation or similar payment methods. Your *copayments* are determined based on our *allowance* at the date the service is rendered. Your *copayment* may be more or less than the amount the *network provider* receives under these alternative payment methods. Your *copayment* will not be adjusted based on these alternative payment methods, or for any payment that is not calculated on an individual claim basis. Our contracts with *providers* may establish a payment *allowance* for multiple *covered healthcare services*, and we may apply a single *copayment* based on these arrangements. In these cases, you will typically be responsible for fewer *copayments* than if your share of the cost had been determined on a per service basis.

How Non-network Providers Are Paid

Except in the special circumstances described below, if you receive care from a *non-network provider*, you are responsible for paying all *charges* for the services you received. You may submit a *claim* for reimbursement of the payments you made.

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. If an *allowance* for a specific *covered healthcare service* cannot be determined by reference to a fee schedule, reimbursement will be based upon a calculation that reasonably represents the amount paid to *network providers*.

When *covered healthcare services* are received from a *non-network provider*, we reimburse you or the *non-network provider*, less any *copayments* and *deductibles,* based on:

- the lesser of:
  - our *allowance*;
  - the *non-network provider's charge*; or
  - the *benefit limit*; or
  - federal or state law, when applicable.

You are responsible for the *deductible*, if one applies, and the *copayment*, as well as any amount over the *benefit limit* that applies to the service you received.

You are responsible for the difference between the amount that the *non-network provider* bills and the payment we make. Generally, we send reimbursement to you, but we reserve the right to reimburse a *non-network provider* directly.

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 R.I. General Law §27-20-49 (Dental Insurance assignment of *benefits*) applies.

Special Circumstances Where Network Level of Benefits Applies:

Under limited circumstances, when you receive *covered healthcare services* from a *non-network provider*, your share of the costs may be at the *network* level of *benefits*, as described below.

Specifically, your *copayment* and *deductible* will apply at the *network* level of *benefits* when you receive *covered healthcare services* from a *non-network provider* in the following circumstances:

- *Emergency* room services (which may include post-stabilization services unless the *non-network provider* determines that you are able to travel using nonmedical transportation or nonemergency medical transportation and obtains your consent in writing before rendering the services)
- Urgent care services
- Ground ambulance services
- *Air ambulance services;*
- We specifically approve the use of a *non-network provider* for *covered healthcare services,* see *Network Authorization* in Section 5 for details;

- *Non-emergency covered healthcare services* rendered by a *non-network provider* at certain *network* facilities*****, unless the non-network provider obtains your consent in writing before rendering the service;
    - For the following circumstances, the *network* level of *benefits* will apply, regardless of whether the non-network provider had obtained that consent:
        - there is no *network provider* available in the *network* facility;
        - the services are furnished as the result of unforeseen or urgent medical needs arising at the time the non-emergency covered healthcare services are furnished:
        - the services are ancillary, such that you would not typically select the *provider* (including, but not limited to, any service relating to emergency medicine, anesthesiology, pathology, radiology, neonatology, diagnostic testing, and those services provided by assistant surgeons, hospitalists, and intensivists).
    - Otherwise, as required by law.

*****For purposes of this section only, certain *network* facilities are: *general hospital*, *general hospital outpatient* department, critical access hospital, and ambulatory surgical center.

Special Circumstances Where Balance Billing From the Non-Network Provider is Prohibited:

In accordance with federal law, when you receive *covered healthcare services* for the limited circumstances listed below, we pay the *non-network provider* directly for those services. The *non-network provider* cannot bill you for the difference between the *non-network provider charges* and the payment we made, known as balance billing. You are responsible for the *network copayment* and *deductible*, if one applies, which will be counted towards your network deductible and out-of-pocket maximum amounts.

- *Emergency* room services (which may include post-stabilization services unless the *non-network provider* determines that you are able to travel using nonmedical transportation or nonemergency medical transportation and obtains your consent in writing before rendering the services);
- Air ambulance services;
- Non-*emergency covered healthcare services* rendered by a *non-network provider* at certain *network* facilities***** unless the *non-network provider* obtains your consent in writing before rendering the services.
    - For the following circumstances the *non-network provider* cannot balance bill you, regardless of whether the non-network provider had obtained that consent:
        - there is no *network provider* available in the *network* facility;
        - the services are furnished as the result of unforeseen or urgent medical needs arising at the time the non-emergency covered healthcare services are furnished;
        - the services are ancillary, such that you would not typically select the *provider* (including, but not limited to, any service relating to *emergency* medicine, anesthesiology, pathology, radiology, neonatology, diagnostic testing, and those services provided by assistant surgeons, hospitalists, and intensivists).

*****For purposes of this section only, certain *network* facilities are: *general hospital*, *general hospital outpatient* department, critical access hospital, and ambulatory surgical center.

If you experience a problem relating to one of the special circumstances described above, please see Section 5 for information about how to submit an appeal.

How BlueCard Providers Are Paid: Coverage for Services Provided Outside Our Service Area

Overview

BCBSRI has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called “Inter-*Plan* Arrangements.” These Inter-*Plan* Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association (“Association”). Whenever you access healthcare services outside the geographic area BCBSRI serves, the *claim* for those services may be processed through one of these Inter-*Plan* Arrangements, as described below.

When you receive care outside of the BCBSRI service area, you will receive it from one of two kinds of *providers*. Most *providers* (“participating *providers*”) contract with the local Blue Cross and/or Blue Shield *Plan* in that geographic area (“Host Blue”). Some *providers* (“nonparticipating *providers*”) don’t contract with the Host Blue. We explain below how we pay both kinds of *providers*.

Inter-Plan Arrangements Eligibility – Claim Types
All *claim* types are eligible to be processed through Inter-*Plan* Arrangements, as described above, except for all dental *benefits*, and those prescription drug *benefits* or vision *benefits* that may be administered by a third party contracted by us to provide the specific service or services.

BlueCard® Program
Under the *BlueCard*® Program, when you receive *covered healthcare services* within the geographic area served by a Host Blue, BCBSRI will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating *providers*.

When you receive *covered healthcare services* outside our service area and the *claim* is processed through the *BlueCard* Program, the amount you pay for *covered healthcare 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 BCBSRI.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare *provider*. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare *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 healthcare *providers* after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of *claims*, as noted above. However, such adjustments will not affect the price we have used for your *claim* because they will not be applied after a *claim* has already been paid.

Negotiated (non–BlueCard Program) Arrangements
With respect to one or more Host Blues, in certain instances, instead of using the *BlueCard* Program, we may process your *claims* for *covered healthcare services* through Negotiated Arrangements for National Accounts.

The amount you pay for *covered healthcare services* under this arrangement will be calculated based on the negotiated price (refer to the description of negotiated price in the BlueCard® Program section above) made available to us by the Host Blue.

Value-Based Programs
If you receive *covered healthcare services* under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the *Provider* Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to us through average pricing or fee schedule adjustments.

The following defined terms only apply to the *BlueCard* section only:

- Care Coordinator Fee is a fixed amount paid by us to *providers* periodically for Care Coordination under a Value-Based Program.
- Care Coordination is organized, information-driven patient care activities intended to facilitate the appropriate responses to an enrolled *member's* healthcare needs across the continuum of care.
- Value-Based Program (VBP) is an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local *providers* that is evaluated against cost and quality metrics/factors and is reflected in *provider* payment.
- *Provider* Incentive is an additional amount of compensation paid to a healthcare *provider* by us, based on the *provider's* compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-insured accounts. If applicable, we will include any such surcharge, tax or other fee as part of the *claim* charge passed on to you.

Nonparticipating Providers Outside Our Service Area

- **Enrolled Member Liability Calculation**

When *covered healthcare services* are provided outside of BCBSRI service area by nonparticipating *providers*, the amount an enrolled *member* pays for such services will generally be based on either the Host Blue's nonparticipating *provider* local payment or the pricing arrangements required by applicable law. In these situations, the enrolled *member* may be responsible for the difference between the amount that the nonparticipating *provider* bills and the payment BCBSRI will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments, including but not limited to, *emergency* services, air ambulance services, and certain *covered healthcare services* rendered by a nonparticipating *provider*.

- **Exceptions**

In some exception cases, BCBSRI may pay claims from nonparticipating healthcare *providers* outside of BCBSRI service area based on the *provider's* billed charge. This may occur in situations where an enrolled *member* did not have reasonable access to a participating *provider*, as determined by BCBSRI. In other exception cases, BCBSRI may pay such claims based on the payment BCBSRI would pay to a local nonparticipating *provider* (as described in the above subsection "How Non-network Providers Are Paid"). This may occur where the Host Blue's corresponding payment would be more than BCBSRI in-service area nonparticipating *provider* payment. BCBSRI may choose to negotiate a payment with such a *provider* on an exception basis.

Unless otherwise stated, in any of these exception situations, the enrolled member may be responsible for the difference between the amount that the nonparticipating healthcare *provider* bills and payment BCBSRI will make for the covered services as set forth in this paragraph.

Blue Cross Blue Shield Global® Core
If you are outside the United States (hereinafter "*BlueCard* service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing *covered healthcare services*. The Blue Cross Blue Shield Global Core is unlike the *BlueCard* Program available in the *BlueCard* service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a *network* of *inpatient*, *outpatient* and professional *providers*, the *network* is not served by a Host Blue. As such, when you receive care from *providers* outside the *BlueCard* service area, you will typically have to pay the *providers* and submit the *claims* yourself to obtain reimbursement for these services.

- *Inpatient* Services: In most cases, if you contact the service center for assistance, *hospitals* will not require you to pay for covered *inpatient* services, except for your cost-share amounts/*deductibles*, coinsurance, etc. In such cases, the *hospital* will submit your *claims* to the service center to begin *claims* processing. However, if you paid in full at the time of service, you must submit a *claim* to receive reimbursement for *covered healthcare services*. *Preauthorization* may be required for non-*emergency inpatient* services.

- *Outpatient* Services: *Physicians*, *urgent care centers* and other *outpatient providers* located outside the *BlueCard* service area will typically require you to pay in full at the time of service. You must submit a *claim* to obtain reimbursement for *covered healthcare services*. *Preauthorization* may be required for *outpatient* services.

- Submitting a Blue Cross Blue Shield Global Core Claim: When you pay for *covered healthcare services* outside the *BlueCard* service area, you must submit a *claim* to obtain reimbursement. For institutional and professional *claims*, you should complete a Blue Cross Blue Shield Global Core *claim* form and send the *claim* form with the *provider's* itemized bill(s) to the service center (the address is on the form) to initiate *claims* processing. Following the instructions on the *claim* form will help ensure timely processing of your *claim*. The *claim* form is available from BCBSRI, the service center or online at www.bcbsglobalcore.com. If you need assistance with your *claim* submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

SECTION 7: COORDINATION OF BENEFITS AND SUBROGATION

Introduction

This Coordination of *Benefits* (COB) provision applies when you or your covered dependents have healthcare coverage under more than one *plan*.

This *Plan* follows the COB rules of payment issued by the Rhode Island Office of the Health Insurance Commissioner (OHIC) in Regulation 230-RICR-20-30-2, and the National Association of Insurance Commissioners (NAIC). From time to time these rules may change before a revised *Benefit* Booklet can be provided. The most current COB regulations in effect at the time of coordination are used to determine the *benefits* available to you.

When this provision applies, the order of *benefit* determination rules described below will determine whether we pay *benefits* before or after the *benefits* of another *plan*.

Definitions

The following definitions apply to this section. For additional definitions, see Section 8. When the defined term is used, it will be *italicized* in this section.

ALLOWABLE EXPENSE means a 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 *Plan* is in force.

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

Vision care services covered under other *plans* are not considered an *allowable expense* under this *Plan*.

PLAN means any of the following that provides *benefits* or services for medical, pharmacy, or dental care treatment. If separate contracts are used to provide coordinated coverage for *members* of a group, the separate contracts are considered parts of the same *plan* and there is no COB among those separate contracts.

1. *Plan* includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel *plans* or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical *benefits* under group or individual automobile contracts; and Medicare or any other federal governmental *plan*, as permitted by law.

2. *Plan* does not include: *hospital* indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited *benefit* health coverage, as defined by state law; school accident type coverage; university student health plans; *benefits* for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental *plans*, unless permitted by law.

Each contract for coverage under numbers 1 or 2 above is a separate *plan*. If a *plan* has
two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *plan*.

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

***SECONDARY PLAN* (*SECONDARY*)** means a *plan* that is not a *primary plan*.

When You Have More Than One Plan with BCBSRI

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

When You Are Covered by More Than One Insurer

A healthcare coverage *plan* is considered the *primary plan* and its *benefits* will be paid first if:

- the *plan* does not use similar COB rules to determine coverage; or
- the *plan* does not have a COB provision; or
- The *plan* has similar COB rules and is determined to be *primary* under the order of *benefit* determination rules described below.

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

The following factors are used to determine which *plan* is *primary* and which *plan* is *secondary*:

- if you are the main *subscriber* or a dependent;
- if you are married, which spouse was born earlier in the year;
- the length of time each spouse has been covered under the *plan*;
- if a parental custody or divorce decree applies; or
- if Medicare is your other coverage then Medicare guidelines will apply.

These factors make up the order of *benefit* determination rules, described in greater detail below:

(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* that covers you as a dependent. If, however, you are a Medicare beneficiary, then, in some instances, Medicare will be *secondary* and the *plan*, which covers you as the main *subscriber* or as a dependent, will be primary.

If one of your dependents covered under this *plan* is a student, and has additional coverage through a student *plan*, then the *benefits* from the student *plan* will be determined before the *benefits* under this *plan*.

(2) Dependent Child
If dependent children are covered under separate *plans* of more than one person, whether a parent or guardian, *benefits* for the child will be determined in the following order:

- the *benefits* of the *plan* covering the parent born earlier in the year will be determined before those of the parent whose birthday (month and day only) falls later in the year;
- if both parents have the same birthday, the *benefits* of the *plan* that covered the parent longer are determined before those of the *plan* which covered the other parent for a shorter period of time;
- 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 healthcare 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*.
- both parents share joint custody, without stating that one of the parents is responsible for the healthcare expenses of the child, the *plans* covering the child will follow the order of *benefit* determination rules outlined above.

(4) Active/Inactive Employee

If you are covered under another *plan* as an active employee, your *benefits* and those of your dependents under that *plan* will be determined before *benefits* under this *plan*. The *plan* covering the active employee and dependents will be the *primary plan*. The *plan* covering that same employee as inactive (including those who are retired or have been laid off) will be the *secondary plan* for that employee and dependents.

(5) COBRA/Rhode Island Extended Benefits (RIEB)

If this *plan* is provided to you under COBRA or RIEB, and you are covered under another *plan* as an employee, retiree, or dependent of an employee or retiree, the *plan* covering you as an employee, retiree or dependent of an employee or retiree will be *primary* and the COBRA or RIEB *plan* will be the *secondary plan*.

(6) Longer/Shorter Length of Coverage

If none of the above rules determine the order of *benefits*, the *benefits* of the *plan* that covered a *member* or *subscriber* longer are determined before those of the *plan* that covered that person for the shorter term.

How We Calculate Benefits Under These Rules

When this *Plan* is *secondary*, it may reduce its *benefits* so that the total *benefits* paid or provided by all *plans* are not more than the total *allowable expenses*. In determining the amount to be paid for any *claim*, the *secondary plan* will calculate the *benefits* it would have paid in the absence of other healthcare coverage and apply that calculated amount to any *allowable expense* under its *plan* that is unpaid by the *primary plan*. The *secondary plan* may then reduce its payment by the amount so that, when combined with the amount paid by the *primary plan*, the total *benefits* paid or provided by all *plans* for the *claim* do not exceed the total *allowable expense* for that *claim*. In addition, the *secondary plan* shall credit to its *plan deductible* any amounts it would have credited to its *deductible* in the absence of other healthcare coverage.

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 *Plan* and we will not have to pay those amounts again.

If we make 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 paid, provide information and assistance, or do whatever is necessary to aid in the recovery of this excess amount. The amount of payments made includes the reasonable cash value of any *benefits* provided in the form of services.

Our Right of Subrogation and/or Reimbursement

Subrogation

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

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

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

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

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

Work Related Insurance

If your employer is self-insured against Workers' Compensation liabilities pursuant to a *plan* for which we provide administrative *claims* management services, we will process payments for healthcare services arising out of work-related illnesses, conditions, or injuries as if the services were covered under this *plan*. For the purposes of any contract between us and a *network provider*, you will be deemed to be a *member* receiving services performed under this *plan*. This section does not apply to services related to work-related injuries for a dependent covered under this *plan*. Consult with *y*our employer to determine whether this section applies to you and what *y*our rights and obligations may be.

Reimbursement
In addition to the subrogation rights described above, we also have reimbursement rights. If you recover money by lawsuit, settlement, or otherwise, we may seek reimbursement from you for *covered healthcare services* for which we paid or will pay. Our reimbursement right applies when you received payment from a third party for *covered healthcare services* we provided under this *plan*, as described in the subrogation section above.

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

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

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

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

Member Cooperation
You further agree:

- to notify us promptly and in writing when notice is given to any third party or representative of a third party of the intention to investigate or pursue a *claim* to recover damages or obtain compensation;
- to cooperate with us and provide us with requested information;
- to do whatever is necessary to secure our rights of subrogation and reimbursement under this *plan*;
- to assign us any *benefits* you may be entitled to receive from a third party. Your assignment is up to the cost of the *covered healthcare services*;
- to give us a first priority lien on any recovery, settlement, or judgment or other source of compensation which may be had by any third party. You agree to do this to the extent of the full cost of all *covered healthcare services* associated with third party responsibility;
- to do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of the *covered healthcare services* provided by this *plan*;
- to serve as a constructive trustee for the benefit of this *Plan* over any settlement or recovery funds received as a result of third party responsibility;

- that we may recover the full cost of the *covered healthcare services* provided by this *Plan* without regard to any *claim* of fault on your part, whether by comparative negligence or otherwise;
- that no court costs or attorney fees may be deducted from our recovery;
- that we are not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your *claim* or lawsuit against any third party; and
- that in the event you or your representative fails to cooperate with us, you shall be responsible for all costs associated with *covered healthcare services* provided by this *plan*, in addition to costs and attorney fees incurred by this *Plan* in obtaining repayment.

SECTION 8: GLOSSARY

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

ALLOWANCE is the amount a *network provider* has agreed to accept for a *covered healthcare service* based on an agreed upon fee schedule. For information about how we pay for healthcare services outside of our service area, please see How *BlueCard Providers* Are Paid: Coverage for Services Provided Outside of the Service Area in Section 6.

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

When you receive *covered healthcare services* from a *non-network provider*, our reimbursement to you or our payment to the *non-network provider*, less any *copayments* and *deductibles,* will be based on:

- the lesser of our *allowance*, the *non-network provider's charge*, or the *benefit limit*: or
- federal or state law, when applicable.

For more information on how non-network providers are paid, see How Non-network Providers Are Paid in Section 6.

AMBULATORY SURGICAL CENTER (FREESTANDING) means a state licensed facility, which is equipped to provide surgery services on an *outpatient* basis.

BENEFIT LIMIT means the total *benefit* allowed under this *Plan* for a *covered healthcare service*. The *benefit limit* may apply to the amount we pay, the duration, or the number of visits for a *covered healthcare service*.

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

BLUE DISTINCTION CENTERS are *network providers* who are recognized by the Blue Cross and Blue Shield Association for delivering high-quality, effective, cost-efficient specialty care.

BLUECARD is a national program in which we and other Blue Cross and Blue Shield *plans* participate. See How *BlueCard Providers* Are Paid: Coverage for Services Provided Outside of the Service Area in Section 6 for details.

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

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

COPAYMENT means either a defined dollar amount (copay) or a percentage of our *allowance* (coinsurance) that you must pay for certain *covered healthcare services*.

COVERED HEALTHCARE SERVICES means any service, treatment, procedure, facility, equipment, drug, device, or supply that we have reviewed and determined is eligible for reimbursement under this *plan*.

DEDUCTIBLE means the amount that you must pay each *plan year* before we begin to pay for certain *covered healthcare services*. See the Summary of Medical *Benefits* for *your plan year deductible, benefit limits* and to determine which services are subject to the *deductible*.

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 *Plan* covers *developmental services* unless specifically listed as not covered.

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 OR INVESTIGATIONAL means any healthcare service that has progressed to limited human application, but has not been recognized as proven and effective in clinical medicine. See *Experimental or Investigational* Services in Section 3 for a more detailed description of the type of healthcare services we consider *experimental or investigational*.

***HABILITATIVE SERVICES* (*HABILITATIVE*)** mean healthcare services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech therapy and other services performed in a variety of *inpatient* and/or *outpatient* settings for people with disabilities.

***HEALTH SAVINGS ACCOUNT* (*HSA*)** is a tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses of the *member* who is covered under a *high deductible health plan*. The *member* must be covered under the *HSA plan* for the months in which contributions are made.

***HIGH DEDUCTIBLE HEALTH PLAN* (*HDHP*)** is a health *plan* that satisfies certain requirements with respect to *deductibles* and out-of-pocket expenses. The *plan* cannot provide payment for any *covered healthcare service* until the *plan year deductible* is satisfied, with the exception of *preventive care services*.

HOSPITAL means a facility:

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

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

    - ***SPECIALTY HOSPITAL*** means a *hospital* or the specialty unit of a *general hospital* that 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 home;
- rest home;
- nursing home;
- home for the aged;
- school and college infirmary;
- *residential treatment facility;*
- long-term care facility;
- *urgent care center* or *freestanding ambulatory surgical center*;
- facility providing mainly custodial, educational or *rehabilitative* care; or
- a section of a *hospital* used for custodial, educational or *rehabilitative* care, even if accredited by the JCAHO or listed in the AHA directory.

INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT is a health care facility that provides any *emergency* service and is geographically separate and distinct, and licensed separately from a *hospital* under applicable State law.

INPATIENT means a person who is admitted to a *hospital* or other licensed healthcare facility for care, and is classified as *inpatient*. You are not *inpatient* when you are in a *hospital* or other health care facility solely for observation, even though you may use a bed or stay overnight. See Observation Services in Section 3 for additional information.

MAXIMUM OUT-OF-POCKET EXPENSE means the total amount or dollar limit you pay each *plan year* for *covered healthcare services*. We will pay up to 100% of our *allowance* for the *covered healthcare service* for the rest of the *plan year* once you have met the *maximum out-of-pocket expense*. See the Summary of Medical *Benefits* for your *maximum out-of-pocket expenses*.

MEDICAL PRESCRIPTION DRUGS are prescription drugs that require administration (or the FDA approved recommendation is for administration) by a licensed healthcare *provider* (other than a pharmacist). These *medical prescription drugs* include, but are not limited to, medications administered by infusion, injection, or inhalation, as well as nasal, topical or transdermal administered medications. *Medical prescription drugs* are covered as a medical *benefit*.

***MEDICALLY NECESSARY* (*MEDICAL NECESSITY*)** means that the healthcare services provided to treat your illness or injury, upon review by BCBSRI are:

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

We will make a determination whether a healthcare service is *medically necessary*. You have the right to appeal our determination or to take legal action as described in Section 5.0. We review *medical necessity* on a case-by-case basis.

The fact that your *provider* performed or prescribed a procedure or treatment does not mean that it is *medically necessary*. We determine *medical necessity* solely for purpose of *claims* payment under this *plan*.

MEMBER means a person enrolled in this *plan*, whether a *subscriber* or other enrolled person.

NETWORK means a group of *providers* that have entered into contracts with us or other Blue Cross and Blue Shield *plans* to participate in the Active Anchor Plan.

NETWORK AUTHORIZATION is the process of obtaining an approval from us to receive *covered healthcare services* from a *non-network provider*.

NETWORK PROVIDER is a *provider* in the Active Anchor *Plan* network that has entered into a contract with us or other Blue Cross and Blue Shield *plans*.

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 *plan*.

NON-NETWORK PROVIDER is a *provider* that is not part of the Active Anchor *Plan network* and has not entered into a contract with us or any other Blue Cross and Blue Shield *plan*.

OUTPATIENT means a person who is receiving care other than on an *inpatient* basis, such as:

- in a *provider's* office;
- in an *ambulatory surgical center* or facility;
- in an *emergency* room; or
- in a clinic.

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

PLAN means the health insurance *benefit* package provided by the *Plan* sponsor. The *Plan* sponsor is the State of Rhode Island.

PLAN YEAR means a twelve (12) month period, determined by your employer. *Benefit limits*, *deductibles* (if any), and your *maximum out-of-pocket expenses* are calculated under this *Plan* based on the *plan year*.

PREAUTHORIZATION is the process of determining whether a *covered healthcare service* is *medically necessary* before you receive the service. *Preauthorization* determines whether a healthcare service qualifies for *benefit* payment, and is not a professional medical judgment. The *preauthorization* process varies depending on whether the service is a medical procedure or a prescription drug.

PREVENTIVE CARE SERVICES means *covered healthcare services* performed to prevent the occurrence of disease as defined by the Affordable Care Act (ACA). See Preventive Care and Early Detection Services in Section 3.

***PRIMARY CARE PROVIDER* (*PCP*)** means, for the purpose of this *plan*, professional *providers* that are family practitioners, internists, and pediatricians. For the purpose of this *plan*, gynecologists, obstetricians, nurse practitioners, and physician assistants may be credentialed as *PCPs.* To find a *PCP* or check that your *provider* is a *PCP*, please use the "Find a Doctor" tool on our website or call the Employee CARE Center.

PROGRAM means a collection of *covered healthcare services*, billed by one *provider*, which can be carried out in many settings and by different *providers*. This *Plan* does not cover *programs* unless specifically listed as covered.

PROVIDER means an individual or entity licensed under the laws of the State of Rhode Island or another state to furnish healthcare services. For purposes of this *plan*, the term *provider* includes a *physician* and a *hospital*.

A *provider* includes:
- midwives;
- certified registered nurse practitioners;
- psychiatric and behavioral health nurse clinical specialists practicing in collaboration with or in the employ of a *physician*;
- counselors in behavioral health; and
- therapists in marriage and family practice.

Healthcare services are only covered if those services are provided within the scope of the *provider's* license.

***REHABILITATIVE SERVICES* (*REHABILITATIVE*)** means healthcare services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired due to being sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of *inpatient* and/or *outpatient* settings. These acute short-term therapies can only be provided by a qualified professional.

RESIDENTIAL TREATMENT FACILITY means a facility which provides a treatment *program* for behavioral health services and is established and operated in accordance with applicable state laws for residential treatment *programs*.

RETAIL CLINIC is a medical clinic licensed to provide limited services, generally located in a retail store, supermarket or pharmacy. A *retail clinic* provides vaccinations and treats uncomplicated minor illnesses such as colds, ear infections, minor wounds or abrasions.

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 is the person who enrolls in this *Plan* and signs the application on behalf of himself or herself and on behalf of the other family members listed as eligible on the application.

SUBSTANCE USE DISORDER means the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) or the International Classification of Disease Manual (ICO) published by the World Health Organization.

URGENT CARE CENTER means a healthcare center which provides care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires *emergency* room care. An *urgent care center* can be affiliated with a *hospital* or other institution or independently owned and operated. These centers may also be 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 healthcare service* under this *plan*.

WE*, *US*,** and ***OUR means Blue Cross & Blue Shield of Rhode Island. Blue Cross & Blue Shield of Rhode Island is the entity that administers healthcare *benefits* on behalf of the *Plan* sponsor. WE, US, or OUR will have the same meaning whether *italicized* or not.

YOU and **YOUR** means the *subscriber* or *member* enrolled for coverage under this *plan*. YOU and YOUR will have the same meaning whether *italicized* or not.

SECTION 9: CONTACT INFORMATION

Type	**Medical**	***Medical Prescription Drugs***
Telephone Numbers:	Employee CARE Center and *Preauthorization*, and Appeals: In state: 401-429-2104; Out of state: 1-866-987-3705; Hearing impaired: 711 *Preauthorization* for Behavioral Health services: 1-800-274-2958 *Preauthorization* for Prescription Drugs covered under this *plan*: 1-855-457-0759	Customer Service: In state: 401-429-2104; Out of state: 1-866-987-3705; Hearing impaired: 711 Home Delivery (Mail Order): 1-855-457-1204 *Preauthorization*: 1-855-457-0759
Website:	www.bcbsri.com	www.bcbsri.com
Fax:	Appeals: 401-459-5005 *Preauthorization* and Appeals for Prescription Drugs covered under this *plan*: 1-855-212-8110	*Preauthorization* and Appeals: 1-855-212-8110
Mailing address to file a claim:	Blue Cross & Blue Shield of Rhode Island *Claims* Department 500 Exchange Street Providence, RI 02903 For Prescription Drugs covered under this *plan:* Prime Therapeutics, LLC. P.O. Box 21870 Lehigh Valley, PA 18002-1870	Prime Therapeutics, LLC. P.O. Box 21870 Lehigh Valley, PA 18002-1870
Mailing address to submit an appeal:	Blue Cross & Blue Shield of Rhode Island Grievance and Appeals Unit 500 Exchange Street Providence, RI 02903 For Prescription Drugs covered under this *plan:* Prime Therapeutics, LLC. Clinical Review Dept. 1305 Corporate Center Drive Eagan, MN 55121	Prime Therapeutics, LLC. Clinical Review Dept. 1305 Corporate Center Drive Eagan, MN 55121

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

How To Find a Doctor or Other Providers
To locate a *network provider* please use the “Find A Doctor” feature on our website or call our Customer Service Department**.**

Emergency Care
If you need *emergency* care, call 911 or go to the nearest *hospital emergency* room. If you are traveling outside our service area and need urgent care, call the Customer Service number provided in the chart above or visit our website and use the “Find A Doctor” feature to find a *BlueCard provider*.

Fraud, Waste and Abuse
If you have concerns about being billed for services you never received, or that your insurance information has been stolen or used by someone else, you may report potential health care fraud, waste or abuse to our Special Investigations Unit by using our confidential anti-fraud hotline at 1-800-830-1444 or by email at SIU@bcbsri.org. You may also send an anonymous letter to us at:

Blue Cross & Blue Shield of Rhode Island
Special Investigations Unit
500 Exchange Street
Providence RI, 02903

SECTION 10: NOTICES AND DISCLOSURES

Behavioral HealthCare Parity

This *Plan* provides parity in *benefits* for behavioral health services. This means that coverage of *benefits* for mental health and *substance* use *disorders* is generally comparable to, and not more restrictive than, the *benefits* for physical health.

Financial requirements, such as *deductibles*, *copayments*, or *benefit limits* that may apply to a behavioral health service *benefit* category, such as *inpatient* services, are not more restrictive than those that apply to most medical *benefits* within the same category.

Different levels of financial requirements to different tiers of prescription drugs are applied without regard to whether a prescription drug is generally prescribed for physical, mental health, or *substance* use *disorders*.

Other requirements, that are not expressed numerically, are applied to behavioral health services in comparable ways as medical *benefits*. Such requirements may include medical management standards, formulary design, *network* tier design or standards for *provider* admission into a *network*.

Genetic Information

This *Plan* does not limit your coverage based on genetic information. We will not:

- adjust premiums based on genetic information;
- request or require an individual or family members of an individual to have a genetic test; or
- collect genetic information from an individual or family members of an individual before or in connection with enrollment under this *Plan* or at any time for underwriting purposes.

Orally Administered Anticancer Medication

If applicable, prescription drug coverage for orally administered anticancer medications is provided at a level no less favorable than coverage for intravenously administered or injected cancer medications covered under your medical *benefit*.

Our Right to Receive and Release Information About You

We are committed to maintaining the confidentiality of your healthcare information. However, in order for us to make available quality, cost-effective healthcare 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;
- healthcare operations;
- case management and *utilization review*;
- coordination of healthcare coverage; and
- health oversight activities.

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

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health *plans* and health insurance issuers offering group healthcare coverage generally may not restrict *benefits* for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the *plan* or issuer may pay for a shorter stay if the attending *provider* (e.g., your *physician*, nurse midwife, or *physician* assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, *plans* and issuers may not set the level of *benefits* or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a *plan* or issuer may not, under federal law, require that a *physician* or other healthcare *provider* obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

This *Plan* 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 child is admitted to a *hospital* following childbirth.

Decisions to shorten *hospital* stays shall be made by the attending *physician* in consultation with and upon agreement with you. In those instances where you and your newborn child 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 newborn child, (any additional visits may be reviewed for *medical necessity*); and
- a pediatric office visit within twenty-four (24) hours after discharge from the *hospital*.

MHM02372
Create Date: 2/22/2023
BB – IER-HSA/Dep26/70/50/Ded:$2000/4,000net$5,000/10,000non/AME:$4,000/8,000net/$10,000/20,000non-net/tele yes,GID yes,IVF yes - with no limits, aut-yes, mast-yes/custom benefits/AC

www.BCBSRI.com

500 Exchange Street • Providence, RI 02903-2699